REPORT 5

PATTON STATE HOSPITAL

December 8-12, 2008

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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Acronyms used in Court Monitor reports:

AA	Alcoholics Anonymous
ACT	Administrative Clinical Team
AD	Administrative Directive
ADR	Adverse drug reaction
AIMS	Abnormal Involuntary Movement Scale
A/N	Abuse/Neglect
ASH	Atascadero State Hospital
A-WRP	Admission Wellness and Recovery Plan
BCC	Behavioral Consultation Committee
BMI	Body Mass Index
CA	Clinical Administrator
CASAS	Comprehensive Adult Student Assessment Systems
CDPH	California Department of Public Health
CET	Consistent Enduring Team
CEU	Continuing Education Units
CHF	Congestive heart failure
CIS	Clinical Information System
CIPRTA	Comprehensive Integrated Physical Rehabilitation Therapy Assessment
CM	Court Monitor
COPD	Chronic Obstructive Pulmonary Disease
COT	Community Outpatient Treatment
C-PAS	Central Psychological Assessment Services
CPR	Cardio-pulmonary resuscitation
CRG	Council Representative Group
CRIPA	Civil Rights of Institutionalized Persons Act
CV	Curriculum vitae (i.e. resumé)
DBT	Dialectical behavioral therapy
DCAT	Developmental and Cognitive Abilities Team
DMH	Department of Mental Health
DOJ	Department of Justice

DPH	Department of Public Health
DPS	Department of Police Services
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (Text Revision)
DTR	Dietetic Technician, Registered
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
EMS	Emergency Medical Service
EP	Enhancement Plan
EPPI	Enhancement Plan Performance Improvement
EPS	Extrapyramidal symptoms
ETRC	Enhanced Therapeutic Review Committee
FRP	Forensic Review Panel
FSP	Family Services Program
FSSW	Family Services Social Worker
FTE	Full time employee, full time equivalent
GAF	Global Assessment of Functioning [Score]
H&P	History and Physical [Examination]
HAC	Hospital Advisory Council
HAI	Hospital-associated infection
HAR	Hospital administrative resident
HIMD	Health Information Management Department
HIV	Human Immunodeficiency Virus
HSS	Health Services Specialist
IA-RTS	Integrated Assessment—Rehabilitation Therapy Section
IC	Infection Control
ICA	Intensive Case Analysis
ICF	Intermediate Care Facility
IDN	Inter-Disciplinary Note
IMRC	Incident Management Review Committee
IPA	Integrated Assessment: Psychology section
IRC	Incident Review Committee
IT	Information Technology

LVN	Licensed Vocational Nurse
MAPP	My Activity and Participation Plan
MIRC	Mortality Interdisciplinary Review Committee
MMSE	Mini Mental Status Examination
MNT	Medical Nutrition Training
MOD	Medical Officer of the Day
MPPN	Monthly Physician's Progress Note
MRSA	Methicillin-resistant Staphylococcus aureus
MSH	Metropolitan State Hospital
MTR	Medication and Treatment Record
MVR	Medication Variance Report
NA	Narcotics Anonymous
N/A	Not applicable
NAC	North Activity Center
NAMI	National Alliance on Mental Illness
NCHPPD	Nursing care hours per patient day
NCMT	Nutrition Care Monitoring Tool
NCS	Neuropsychological Consultation Service
NGA	New generation antipsychotic
NOC	Nocturnal shift
NOS	Not otherwise specified
NP	Nursing Policy
NPO	Nulla per Os (nothing by mouth)
NRT	Narrative Restructuring Therapy
NSH	Napa State Hospital
NST	Nutritional Status Type
OSI	Office of Special Investigations
OT	Occupational Therapy/Therapist
PBS	Positive Behavior Support
PC	Penal Code
PFA	Psychology Focused Assessment
PHN	Public health nurse

PIO	Public Information Officer
PMAB	Prevention and Management of Assaultive Behavior
PMHNP	Psychiatric Mental Health Nurse Practitioner
PMOD	Psychiatric Medical Officer of the Day
POST	Physical, Occupational, and Speech/Language Pathology
PPD	Purified Protein Derivative (skin test for tuberculosis)
PPN	Physician's Progress Note
PRA	Patient Rights Advocate
PRN	Pro re nata (as needed)
PSH	Patton State Hospital
PSR	Psychosocial Rehabilitation
PSS	Psychology Specialty Services
PSSC	Psychology Specialty Services Committee
PT	• Physical Therapy/Therapist (in Sections D.4 and F.4) • Psychiatric Technician (in Sections D.3 and F.3)
P&T	Pharmacy and Therapeutics [Committee]
RD	Registered Dietician
RIAT	Rehabilitation Integrated Assessment Team
RMS	Records Management System; Recovery Mall Services
RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
S&R	Seclusion and Restraint
SA	Substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
S/P	Status post
SRA	Suicide Risk Assessment
SSI	Supervising Special Investigator
TB	Tuberculosis

TD	Tardive dyskinesia
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
WaRMSS	Wellness and Recovery Model Support System
WRAP	Wellness and Recovery Action Plan
WRP	Wellness and Recovery Plan
WRPC	Wellness and Recovery Planning Conference
WRPT	Wellness and Recovery Planning Team

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Jackman, OTR/L) visited Patton State Hospital (PSH) from December 8 to 12, 2008 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

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

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

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

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

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

B. Methodology

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

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

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

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

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

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

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

C. Statistical Reporting

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

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

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

D. Findings

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

1. Key Indicator Data

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

factors that contribute to changes in facility trends and patterns.

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

a. Allegations of abuse/neglect were on average higher for this review period than for previous review periods. This could be the result of improved reporting and data collection and all allegations may not be sustainable, but regardless this is a high-priority issue for the facility.
b. Data related to weight (e.g. body mass index and waist circumference) should be evaluated to validate the sharp decline in November 2008.
c. Data on use of illicit drugs shows an apparent non-random pattern that should be assessed.
d. The decline in medication variances due to documentation errors should not be relied upon given the repeated failures to complete medication variance reports for some types of documentation errors.
e. The kinks appear to have been worked out of data collection regarding WRP non-adherence, but non-adherence rose more than 50% between August and October 2008.
f. The 26% increase in seizure disorder diagnoses between June and July 2008 should be evaluated.
g. An explanation for the sharp rise and decline in the use of phenytoin may provide an opportunity for performance improvement that could be generalized to other conditions/medication uses.
h. The pattern of fracture diagnoses is perplexing.
i. The repetitive use of PRN and Stat medications increased during the most recent review period.
j. The incidence of restraint continues to decline, and seclusion is rarely used.

2. Monitoring, mentoring and self-evaluation

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

a. PSH has refined most of the structures and processes that are required for implementation of the EP. The facility has initiated the process of systemic and periodic review of the self-assessment data and this monitor's findings to ensure consistent feedback to the WRPTs and disciplines, identify trends and patterns and implement targeted corrective actions. In particular, the facility's review and analysis of various categories of WRPTs' performance provided clear and concise guide to the facility's management regarding current status and plans of correction.
b. Regarding the process of self-assessment, this monitor has requested the following:
    i. For data demonstrating compliance rates of less than 90% with the main indicators, all facilities should provide the following information:

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

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

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

c. PSH has presented data comparing the compliance rates from this review period to the previous period and from the month of the current review period to the last month of the last review period as requested. In addition, the facility presented information on the barriers towards compliance, as indicated and plans of correction, as applicable.

d. With few exceptions, the DMH has standardized the auditing tools required for self-monitoring across state facilities. PSH has utilized these tools for all applicable sections of the EP.

e. The practice of self-monitoring has taken further root at PSH. All facilities are encouraged to ensure that this practice reliably informs performance improvement in the systems of clinical care.

f. The DMH currently has sufficient monitoring tools to ensure meaningful self-assessment of EP implementation. With few exceptions, there appears to be no need to develop new monitoring tools this stage. However, the existing monitoring tools should be viewed as dynamic instruments that continually respond to realities of clinical practice and updates in current standards of care.

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

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

3. Implementation of the EP

a. Since the last review period, PSH has made progress in the implementation of requirements of the EP. This progress is summarized in each corresponding section in the body of the report.

b. PSH has yet to make significant progress to address the process deficiencies in medical and nursing care. The DMH has developed draft Special Order (SO), Provision of Medical Care to Individuals and medical and nursing care templates and protocols. These tools contain appropriate mechanisms that, if properly implemented, can improve the processes of nursing and medical care and strengthen the facility's efforts to achieve compliance with the EP in these areas.
c. PSH has yet to make significant progress in the current incident and risk management systems. The facility needs to implement an updated system, including identification of triggers and thresholds regarding high-risk behavior, establishment of levels of interventions corresponding to the level of risk and appropriate notification and follow-up mechanisms. The interventions and follow-up should include, but not be limited, to the following:
   i. First-level response by the WRPTs, including timely review of incidents and analysis of contributing factors, timely and appropriate use of Stat and PRN medications, judicious use of restrictive interventions in accord with current DMH procedures and use of positive behavior supports whenever indicated as well as other corrective actions, as needed;
   ii. Second-level review by clinical leadership;
   iii. Outside consultations, if necessary; and
   iv. An oversight mechanism to review trends and patterns and initiate systemic performance improvement projects. The DMH has developed a draft Risk Management SO that includes appropriate mechanisms regarding the identification of individuals at risk and interventions to reduce the level of risk. If properly implemented, this SO can strengthen the facility's efforts to achieve compliance with the EP requirements in the areas of incident and risk management.
d. Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH seriously consider standardizing across all hospitals the Administrative Directives that impact these services.
e. Functional/clinical outcomes of the current structural changes have yet to be finalized and implemented to guide further implementation.
f. 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: Several disciplines in the acute service provided the required number of facilitation/therapy hours on average during the review period, as did several non-clinical classifications. Progress remains to be made regarding the Mall contributions of disciplines in the long-term service, psychiatry in general, and nursing. Nursing hours of service provided in the Mall were minimal, even taking the nursing position vacancy rate into account.

      The following table provides the minimum average number of hours of Mall services that DMH facilities should provide:

DMH PSR MALL HOURS REQUIREMENTS

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

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

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

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

ii. **Progress notes**: PSH has yet to ensure that providers of Mall groups and individual therapy complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.

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 WRPT psychologist to determine whether a referral to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

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

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. All facilities must ensure that this service is available to this group of individuals.

4. Staffing

The table below shows the staffing pattern at PSH as of October 31, 2008:

Patton State Hospital Vacancy Totals as of October 31, 2008

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5	5	0	0%
Assistant Director of Dietetics	5	5	0	0%
Audiologist I	1	1	0	0%
Chief Dentist	1	1	0	0%
Chief Physician & Surgeon	1	1	0	0%
Chief, Central Program Services	0	0	0	0%
Chief Psychologist	1	1	0	0%
Clinical Dietician/Pre-Reg. Clin. Dietician	11	9	2	18%
Clinical Laboratory Technologist	1	1	0	0%
Clinical Social Worker	102.5	99	3.5	3%
Coordinator of Nursing Services	1	1	0	0%
Coordinator of Volunteer Services	1	1	0	0%
Dental Assistant	4	4	0	0%
Dentist	2	2	0	0%
Dietetic Technician	4	3	1	25%
E.E.G. Technician	0	0	0	0%
Food Services Technician I and II	118	112.5	4.5	4%

Patton State Hospital Vacancy Totals as of October 31, 2008				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Hospital Worker	0	0	0	0%
Health Record Technician I	6	6	0	0%
Health Record Techn II Spec	3	3	0	0%
Health Record Techn II Supv.	1	0	1	100%
Health Record Techn III	1	1	0	0%
Health Services Specialist	25	21	4	16%
Institution Artist Facilitator	0	0	0	0%
Licensed Vocational Nurse	81	79	2	2%
Medical Technical Assistant	0	0	0	0%
Medical Transcriber	6	6	0	0%
Medical Transcriber Sup	0	0	0	0%
Sr Medical Transcriber	0	0	0	0%
Nurse Instructor	5	5	0	0%
Nurse Practitioner	5	5	0	0%
Nurse Coordinator	11	11	0	0%
Office Technician	29	26	3	10%
Pathologist	0	0	0	0%
Pharmacist I	16	15	1	6%
Pharmacist II	1	0	1	100%
Pharmacist Services Manager	1	1	0	0%
Pharmacy Technician	11	11	0	0%
Physician & Surgeon	21	20.75	0.25	1%
Podiatrist	1	1	0	0%

Patton State Hospital Vacancy Totals as of October 31, 2008				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Pre-Licensed Pharmacist	0	0	0	0%
Pre-Licensed Psychiatric Technician	30	30	0	0%
Program Assistant	8	8	0	0%
Program Consultant (RT,PSW)	2	1	1	50%
Program Director	8	8	0	0%
Psychiatric Nursing Education Director	1	1	0	0%
Psychiatric Technician	723	705	18	2%
Psychiatric Technician Trainee	0	0	0	0%
Psychiatric Technician Assistant	37.1	35	2.1	6%
Psychiatric Technician Instructor	1	1	0	0%
Psychologist-HF, (Safety)	79.9	74.7	5.2	7%
Public Health Nurse II	2	2	0	0%
Radiological Technologist	1	1	0	0%
Registered Nurse	360.2	362	-1.8	0%
Reg. Nurse Pre Registered	0	0	0	0%
Rehabilitation Therapist	95	77.75	17.25	18%
Special Investigator	3	2	1	33%
Special Investigator, Senior	2	2	0	0%
Speech Pathologist I	1	1	0	0%
Sr. Psychiatrist (Spvr)	23.2	8	15.2	66%
Sr. Psychologist (Spvr and Spec)	15	10.25	4.75	32%
Sr. Psych Tech (Safety)	81	81	0	0%
Sr. Radiological Technologist (Specialist)	1	1	0	0%

Patton State Hospital Vacancy Totals as of October 31, 2008				
Identified Clinical Positions	**Budgeted Positions**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Sr. Voc. Rehab. Counselor/Voc.Rehab. Counselor2	2	2	0	0%
Staff Psychiatrist	81.2	69.5	11.7	14%
Supervising Psychiatric Social Worker	0	0	0	0%
Supervising Registered Nurse	2	2	0	0%
Supervising Rehabilitation Therapist	0	0	0	0%
Teacher-Adult Educ./Vocational Instructor	16.5	11	5.5	33%
Teaching Assistant	0	0	0	0%
Unit Supervisor	33	33	0	0%
Vocational Services Instructor (Landscp Gardn) (S)	1	1	0	0%

Critical vacancies at this time include senior psychiatrists and psychologists and staff psychiatrists.

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

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

Finally, there is a shortage of hospital police officers and Special Investigators across DMH facilities. This shortage compromises the timeliness of the practices and procedures required for compliance with Section I of the Enhancement Plan. Salary appears to be the key reason that the facilities have not been able to recruit additional staff and have lost staff to the Corrections Department and local communities, despite DMH's vigorous recruitment and training efforts. This situation is serious and must be reversed to achieve compliance.

E. 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.
7. At least two of the hospitals (i.e., PSH and ASH) have reached substantial compliance in one section of the EP. Once a hospital reaches substantial or full compliance in a section of the EP, the CM begins maintenance evaluation of that section for 18 consecutive months. If the hospital maintains substantial or full compliance during the 18-month period, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel to assume this responsibility as each section of the EP achieves maintenance status at each hospital.

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Patton State Hospital June 8-12, 2009.
2. The Court Monitor's team is scheduled to tour Napa Hospital January 26-30, 2009 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

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 developed and implemented an adequate mechanism for WRP data presentation and data-based corrective actions. 2. PSH has developed and begun implementation of a new format for a meaningful and more concise monthly WRPC. 3. In general, PSH has made further progress in the WRPC process. 4. PSH has improved the staffing ratios for psychologists on the admission units and has recently recruited 12 psychologists and 13 RTs in an effort to achieve compliance with the required ratios on all units. 5. In general, the review of the present status section of the case formulation was much improved, including the review of symptoms, interventions and response, functional status, risk factors, progress towards discharge criteria, By Choice point allocation and medication side effects. 6. In general, PSH has made progress in the development of learning-based objectives and interventions for individuals with seizure disorders. 7. In collaboration with MSH, PSH has developed a state-of-the-art Substance Abuse Performance Improvement plan. 8. PSH has begun the processes of providing WRP and medication education groups based on individuals' needs.
1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** <u>Interviewed</u>: 1. Gari-Lyn Richardson, Director, Standards Compliance 2. George Christison, MD, Acting Chief of Psychiatry 3. Hope Marriott, LCSW, WRP Master Trainer 4. Julia Fleming, RT, WRP Master Trainer

		5. Robbin Huff-Musgrove, PhD, WRP Master Trainer Reviewed: 1. Summary outline of PSH's data analysis of WRPT performance 2. Outline of WRP training provided to WRPTs, May to October 2008 3. PSH template for a Focused Monthly WRPC 4. DMH WRP Process Observation Monitoring Form 5. DMH WRP Process Observation Monitoring Form Instructions 6. PSH WRP Process Observation Monitoring summary data (May to October 2008) 7. DMH Clinical Chart Auditing Form 8. DMH Clinical Chart Auditing Form Instructions 9. PSH Clinical Chart Auditing summary data (May to October 2008) 10. DMH WRP Team Leadership Auditing Form 11. DMH WRP Team Leadership Auditing Form Instructions 12. PSH WRP Team Leadership Auditing summary data (May to October 2008) 13. PSH data regarding staffing ratios on admission and long-term units (May to October 2008) Observed: 1. WRPC (Program I, unit 5) for 14-day review of JC 2. WRPC (Program I, unit 74) for monthly review of HMC 3. WRPC (Program IV, unit 36) for monthly review of PAS 4. WRPC (Program IV, unit 37) for monthly review of TLZ 5. WRPC (Program V, unit 23) for quarterly review of AAM 6. WRPC (Program VI, unit 9) for 14-day review of EDR 7. WRPC (Program VI, unit 10) for monthly review of RA 8. WRPC (Program VI, unit 71) for 7-day review of KDK 9. WRPC (Program VI, unit 71) for 7-day review of MB 10. WRPC (Program VII, unit 76) for quarterly review of RB 11. WRPC (Program VIII, unit 21) for monthly review of LWM 12. WRPC (Program VIII, unit 25) for quarterly review of JAG

C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her liberty interests, including the interests of self determination and independence.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Continue current WRP mentoring program and WRP Overview training. • Implement formal training of WRPTs using the modules regarding Engagement, Case Formulation, Foci/Objectives/Interventions, Team Leadership and Discharge Planning/Community Integration. **Findings:** The following summarizes the facility's actions since the last report: 1. The Acting Chief of Psychiatry, George Christison, MD, has continued to provide primary leadership on efforts to enhance WRPT performance and the WRP mentor program. 2. Jana Larmer, PhD was replaced by Robbin Huff-Musgrove, PhD as the psychology master trainer. 3. Hope Marriott LCSW was hired as a social work master trainer. 4. The facility continued the WRP Overview training course. 5. In August 2008, referral-based training in the MSH modules (Engagement, Case Formulation, Foci and Objectives, Interventions and Mall Integration and Discharge Planning) was initiated. The materials in the modules were not changed. Criteria for referral were developed. 6. In October 2008, mentor assignments were updated to address the needs of the WRPTs that were lagging most. 7. A new format for a monthly WRPC was developed to streamline the steps and ensure a more focused review within the allocated timeframe. 8. In October 2008, WRP mentors received two trainings in the focused monthly conference format. 9. A "WRP Data Feedback" report was developed to provide team-specific audit data to WPRTs. The data were organized within two

main areas: WRPC (based on observation monitoring) and WRP content (based on clinical chart auditing).

10. Using the above-mentioned process, the facility conducted data analysis at three levels: a) how programs compared with each other; b) how units compared with each other; and c) how WRPTs compared with each other both within their own programs and also relative to teams across the facility. The analysis yielded meaningful data regarding barriers hospital-wide.
11. In late October, the initial set of data feedback reports were distributed to mentors to discuss with their WRPTs.

Recommendation 3, June 2008:
Provide documentation of results of competency-based training of WRPTs in all WRP training courses.

Findings:
PSH provided data on the percentages of WRPT members hospital-wide who successfully completed the overview training during this review period. The comparative data showed sustained performance and in some cases incremental improvement since the last review:

Overview training		
Discipline	**Previous review**	**Current review**
MD	95%	97%
PhD	100%	100%
SW	100%	100%
RT	100%	100%
RN	97%	99%
PT	97%	98%

As mentioned above, training on the five MSH modules was initiated during this review period based on a referral system. The facility

presented data regarding the percentages of WRPTs that successfully completed this training. The data did not address various core disciplines that completed this training. The following is a summary of the facility's data:

Other WRP training	
Training module	**% of WRPTs that were referred and successfully completed training**
Engagement	60%
Case Formulation	60%
Foci and Objectives	90%
Interventions and Mall Integration	60%
Discharge Planning	63%

The facility identified problems in the implementation of the referral-based system of training, including inadequacy of referral numbers and the lack of adequate accountability for non-compliance with the training.

Corrective actions and plans included the following:

1. The leadership and management of this training program was changed and assigned to Robin Huff-Musgrove, PhD and Hope Marriott, MSW, WRP master trainers.
2. Much of the training has been moved to the conference rooms of the referred WRPTs to allow for better attendance and more personalized training.
3. Criterion for referral to modules will be revised and will include data from the Discharge Planning Audit.
4. Identified team members who do not comply with mandatory training will be referred to program managers and discipline chiefs to ensure completion of the assigned training.

		5. Mentors will be instructed to focus particularly on specific items that had contributed to the WRPT being referred to the training. **Recommendation 4, June 2008:** Simplify the process of the monthly WRPCs to ensure that these reviews provide updates of the status of the individuals that can be completed within a reasonable timeframe. **Findings:** PSH developed an adequate format for a concise monthly conference. The format was designed to focus on planning and revising treatment and involving the individual with as much of the planning as possible. The new format was piloted in several of the better-performing WRPTs and was found to produce conferences that rarely extended beyond 30 minutes. The WRP mentors were trained in the concise monthly format twice in October 2008 and have begun mentoring their teams on proper implementation. **Recommendation 5, June 2008:** Monitor this requirement using the DMH Clinical Chart Auditing Form based on a 20% sample and provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Clinical Chart Auditing Form, but the average sample (2%) was too small to permit meaningful review of the data. **Recommendation 6, June 2008:** Provide a summary outline of any improvements in practice made as a result of review by the facility of internal monitoring data.

		Findings: As mentioned above, the facility has developed and begun implementation of a new format for a meaningful and more concise monthly WRPC. **Other findings:** The monitor and his experts attended 12 WRPCs. The meetings showed further progress in the overall process of the team meetings. The following are examples: 1. All meetings started on time. 2. Most team meetings included the required number of core members, including participation by PTs. 3. Several psychiatrists demonstrated skill in facilitating meaningful WRPCs. 4. Most WRPTs presented an adequate summary of the assessment data, and provided adequate review of risk factors prior to the individual's arrival. 5. The review and update of the present status section of the case formulation was generally more organized and comprehensive than observed during the previous review. 6. Most WRPTs discussed the key questions to be addressed during the individual's presence. 7. In all the meetings that included the individuals, the team members were respectful of the individuals and made appropriate efforts to elicit their input. 8. Most WRPTs reviewed the diagnosis, objectives and interventions with the individual. 9. The teams made an effort to review the individual's attendance (and participation) at the assigned groups. 10. The teams reviewed the By Choice participation and point allocation with the individual. 11. In one meeting, the WRPT provided an example of success in

		effective communications with an individual who had a hearing disability and a cognitive disorder and demonstrated, during the meeting, positive outcomes for the individual, in both communications and cognitive status. However, the meetings showed the following pattern of process deficiencies: 1. A few WRPTs did not follow the WRPC process steps and appeared to be at a loss regarding the direction and goals of the conference. 2. Some WRPTs did not attend to important clinical information provided by the individuals during the meeting, failing to ask important follow-up questions to evaluate the individual's current functional status. 3. Some WRPTs did not use important clinical information provided by the individuals during the meeting to update the precipitating factors section of the case formulation or the precursors to danger section of the court report. 4. The WRPTs provided inconsistent accounts regarding the process of mentoring and one WRPT complained about not having mentors to provide feedback or address the team's questions. 5. Most of the WRPTs did not update the individuals' life goals and strengths. 6. Most of the WRPTs did not link the WRP objectives and interventions with the individual's life goals and strengths. 7. Most of the teams did not review the Mall Facilitator Notes or use a mechanism to ensure that Mall offerings are properly linked to the WRP objectives and the individual's cognitive level of functioning. 8. Some teams did not discuss progress towards specific discharge criteria with the individual.

		Compliance: Partial. **Current recommendations**: 1. Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. 2. Ensure that all WRPTs that require training in the MSH modules receive this training. 3. Provide documentation of results of competency-based training of WRPTs in all WRP training courses. Present the data for each discipline and compare mean rates during the review period with the rates during the previous period. 4. Ensure facility-wide implementation of the format for the focused monthly WRPC. 5. Improve clinical mentoring of the WRPTs to ensure proper attention to important clinical data during the meeting. The mentors must regularly attend the conferences and provide consistent face-to-face feedback to the teams. 6. Provide a summary outline of any improvements in practice made as a result of review of internal monitoring data by the Quality Council.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on samples of 20% and 100%, respectively. • Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH WRP Observation Monitoring Form to assess

compliance (May to October 2008). The average sample size was 11% of all WRPCs due each month.

1.	*Each team is led by a clinical professional who is involved in the care of the individual:*	
1.a	*The clinical professional is a core team member for the individual.*	93%
1.b	*This person is the identified facilitator or the team leader appointed a team facilitator.*	93%

Comparative data showed improved compliance since the last review as follows:

Item	Mean %C previous period	Mean %C current period
1.	20%	93%

The facility also used the DMH WRP Team Leadership Auditing Form to assess compliance (May to October 2008). Recently, this tool was slightly revised to ensure that only those functions related to the role of the team leader were included. The data were based on two observations per unit team by senior supervising psychiatrists per month. The average sample was 20% of the required observations (two observations per unit team by senior supervising psychiatrists per month). The following is a summary of the data:

1.	*Psychiatrist was present.*	97%
2.	*Psychiatrist elicited the participation of all disciplines.*	92%
3.	*Psychiatrist ensured the (integration of) assessments from other disciplines into the case formulation.*	81%
4.	*Psychiatrist ensured the "Present Status" section in the Case Formulation was updated.*	36%
5.	*Psychiatrist ensured that the interventions were linked to the measurable objectives.*	57%

Comparative data showed mixed changes since the last review. The following is a summary:

	Previous period	Current period
Mean compliance rate		
1.	100%	97%
2.	93%	92%
3.	77%	81%
4.	41%	36%
5.	59%	57%
Compliance rate in last month of period		
1.	100%	96%
2.	93%	89%
3.	77%	65%
4.	41%	28%
5.	59%	36%

The facility's corrective action plan consisted of the same actions that were outlined under section C.1.a.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on samples of 20% and 100%, respectively.
2. Continue data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

C.1.c	Function in an interdisciplinary fashion.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH WRP Observation Monitoring Form to assess compliance (May to October 2008). The average sample was 11% of all WRPCs. The following is a summary of the data:

2.	*Each team functions in an interdisciplinary fashion.*	19%
2.a	*The core team members participate by presenting or updating discipline-specific and/or holistic assessment data*	31%
2.b	*The team reviews and updates the DMH WRPC Task Tracking Form.*	62%
2.c	*Team members present their assessments and consultations as listed in the Task Tracking Form.*	22%
2.d.	*Team members discuss the individual's specific outcomes for the WRP review period.*	30%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	0%	19%

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>0%</td><td>68%</td></tr>
<tr><td>2.a</td><td>5%</td><td>97%</td></tr>
<tr><td>2.b</td><td>46%</td><td>72%</td></tr>
<tr><td>2.c</td><td>10%</td><td>39%</td></tr>
<tr><td>2.d</td><td>2%</td><td>88%</td></tr>
</table>

PSH identified the WRPTs' inconsistent use of the Task Tracking Form during the WRPCs as the main contributor to lower compliance in this cell. The plan of correction included the same actions outlined in C.1.a.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using process observation based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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<td>C.1.d</td>
<td>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, June 2008:
• Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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Findings:
The following is a summary of the facility's compliance data based on the previously mentioned observation monitoring process (May to October 2008):

1.	*Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.*	29%
1.a	*The present status and previous response to treatment sections of the case formulation are aligned with the assessments (focused assessment of compliance)*	39%
1.b	*A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes (Global assessment of compliance)*	54%

Comparative data showed mixed changes since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	2%	29%
Compliance rate in last month of period		
1.	43%	45%
1.a	48%	45%
1.b	72%	64%

The facility's plan of correction was outlined in C.1.a.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the DMH WRP Observation Monitoring Form, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** The following is a summary of the facility's observation monitoring data (May to October 2008): 3. *Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring and, as necessary, revising the therapeutic and rehabilitative services.* — 13% 3.a *Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.* — 20%

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<tr><td>3.b</td><td>Team members present their assessments and consultations as listed in the Task Tracking Form.</td><td>18%</td></tr>
<tr><td>3.c</td><td>Team members discuss the individual's specific outcomes for the WRP review period.</td><td>16%</td></tr>
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Comparative data showed mixed changes since the last review as follows:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>3.</td><td>0%</td><td>13%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>3.</td><td>0%</td><td>55%</td></tr>
<tr><td>3.a</td><td>1%</td><td>75%</td></tr>
<tr><td>3.b</td><td>10%</td><td>45%</td></tr>
<tr><td>3.c</td><td>1%</td><td>61%</td></tr>
</table>

The facility's plan of correction was outlined in C.1.a.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH WRP Observation Monitoring Form, based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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<td>C.1.f</td>
<td>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of</td>
<td>Current findings on previous recommendation:</td>
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	those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Recommendation, June 2008:** Same as in C.1.a through C.1.e. **Findings:** Same as in C.1.a through C.1.e. **Other findings:** PSH used the DMH Observation Monitoring Form (May to October 2008) and reported a mean compliance rate of 11% for this requirement (compared to 0% during the last review). The mean rate for the last month of this period was 51% (compared to 0% in the last month of the previous review period). Corrective actions were outlined in C.1.a. **Compliance:** Partial. **Current recommendations**: Same as in C.1.a through C.1.e.
C.1.g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the DMH WRP Observation Monitoring Form, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** The facility's observation monitoring data (May to October 2008) are summarized as follows:

5.	*The team identified someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.*	34%
5.a	*There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP.*	85%
5.b	*The identified recorder drafts the WRP on the computer and obtains all necessary signatures on the completed WRP, schedules the next conference date and time, Fills out the appointment card for the next WRPC for the individual and fills out the WRPC Task Tracking form at the conference.*	36%

Comparative data showed improved compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	9%	34%
Compliance rate in last month of period		
5.	12%	73%
5.a	91%	92%
5.b	14%	80%

The facility's corrective actions were outlined in C.1.a.

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<td>Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH WRP Observation Monitoring Form, based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
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<tr>
<td>C.1.h</td>
<td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2008:
• Regularly monitor the attendance by core members, including the individuals, at the WRPCs.
• Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
PSH presented attendance data based on the WRP observation process (May to October 2008). The average sample was 11% of the WRPCs. The following table summarizes the attendance rates by each core member during this review period in comparison to the last review period:
<table>
<tr><td>WRPT member</td><td colspan="2">Mean Attendance Rate</td></tr>
<tr><td></td><td>Previous Period</td><td>Current Period</td></tr>
<tr><td>Individual</td><td>86%</td><td>85%</td></tr>
<tr><td>Psychiatrist</td><td>89%</td><td>90%</td></tr>
<tr><td>Psychologist</td><td>62%</td><td>64%</td></tr>
<tr><td>Social Worker</td><td>77%</td><td>76%</td></tr>
<tr><td>Rehabilitation Therapist</td><td>60%</td><td>57%</td></tr>
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<table>
<tr><td>WRPT member</td><td colspan="2">Mean Attendance Rate</td></tr>
<tr><td></td><td>Previous Period</td><td>Current Period</td></tr>
<tr><td>Registered Nurse</td><td>23%</td><td>82%</td></tr>
<tr><td>Psychiatric Technician</td><td>7%</td><td>48%</td></tr>
</table>

Comparative data showed significantly improved attendance by RNs and PTs since the last review.

Compliance:
Partial.

Current recommendations:
1. Continue current efforts to improve attendance by core members.
2. Monitor this requirement using process observation based on at least a 20% sample.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
4. Recruit sufficient staff to fill current vacancies in core WRPT members.
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<td>C.1.i</td>
<td>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.</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2008:
Address and correct factors related to low compliance.

Findings:
Since September 2008, PSH has reportedly hired twelve psychologists and 13 rehabilitation therapists, many of whom had not arrived on their units during this reporting period; therefore, the current data do not reflect these hires. The facility anticipates that the new hires will result in improved ratios during the next reporting period.
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The following table summarizes the facility's data regarding admission units for this review period compared to the last period. The data showed that PSH has achieved compliance with MD and PhD ratios and maintained compliance for RNs and PTs.

Discipline	Mean Discipline Member:Individuals Ratio, Admission Units	
	Previous Period	Current Period
MDs	1:16	1:15
PhDs	1:20	1:15
SWs	1:16	1:15
RTs	1:16	1:16
RNs	1:6	1:6
PTs	1:3	1:3

The following table summarizes the data for long-term units. The data showed no significant change from the last review period.

Discipline	Mean Discipline Member:Individuals Ratio, Long-Term Units	
	Previous Period	Current Period
MDs	1:28	1:28
PhDs	1:44	1:42
SWs	1:23	1:25
RTs	1:41	1:39
RNs	1:8	1:8
PTs	1:3	1:3

Compliance:
Partial.

		Current recommendations: 1. Ensure compliance with the required ratios for Social Workers on the admission units and for psychologists, social workers and rehabilitation therapists on the long-term units. 2. Provide data regarding staffing case loads on both the admission and long-term units.
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in C.1.a through C.1.f. **Findings:** Same as in C.1.a through C.1.f. However, the facility presented data for this requirement that were inconsistent with the data that were presented in C.1.a regarding the RN and PT disciplines. **Compliance:** Partial. **Current recommendations**: 1. Same as in C.1.a through C.1.f. 2. Ensure accuracy and consistency of training data.

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** <u>Interviewed</u>: 1. Individuals EL and JM 2. Alejandro Fernandez, Supervising Rehabilitation Therapist 3. Amanda Cavicchi, RT 4. Brian Starck-Riley, Assistant Director of Nutrition Services 5. Carlos Luna, Executive Director, Patton State Hospital 6. Caroline Pangan, RN 7. Carson Chambers, PhD 8. Curt Peters, Supervising Rehabilitation Therapist 9. Debi Elliott, PT 10. Debra Taylor-Tatum, Supervising Rehabilitation Therapist 11. Diana Tran, Assistant Director of Nutrition Services 12. Dolores Otto-Moreno, Assistant Director of Nutrition Services 13. Gari-Lyn Richardson, Director, Standards Compliance 14. George Christison, MD, Acting Chief of Psychiatry 15. Grace Ferris, Assistant Director of Nutrition Services 16. Greg Siples, Chief of Rehabilitation Therapy Services 17. Jacqueline Doss-Haynes, Supervising Rehabilitation Therapist 18. Jeanie Kim, Assistant Director of Nutrition Services 19. Kate Madigan, RT 20. Kitchie Miana, Assistant Director of Nutrition Services 21. Liberty Olive Macias, RN 22. Lila Martin, LCSW 23. Lilia Schoen, PT 24. Mark Camero, Supervising Rehabilitation Therapist 25. Melanie Byde, PhD, Mall Director 26. Melissa Roskos, RT 27. Mike Gomes, Supervising Rehabilitation Therapist 28. Mona Mosk, PhD, Psychologist 29. Monireh Moghadam, LCSW

		30. Ninha Simms, LCSW 31. Penny Jarvis, PT 32. Raafat Guirgis, MD, Substance Abuse Program Director 33. Robert Quijada, RT 34. Stan Hydinger, Supervising Rehabilitation Therapist 35. Steven Berman, PhD, Psychologist, By Choice Coordinator 36. Tai Kim, Director of Nutrition Services <u>Reviewed</u>: 1. Charts of the following 197 individuals: AAA, AAC, AG, AGW, AH, AJB, AKA, AKK, AKS, ALO, AM, AMO, ANA, ANM, ASM, ATL, BD, BDS, BKP, BLG, BLM, BM, BMS, BN, BRC, BRT, CAZ, CCS, CD, CH, CHF, CL, CMJ, CRM, CT, CY, DAD, DAH, DAR, DAR-2, DB, DBM, DDP, DET, DFV, DFV-2, DLD, DMZ, DNW, DS, DWL, ECA, EF, EJM, EJM-2, ELF, ELF-2, EM, END, EP, EWM, FLL, GA, GAJ, GC, GCD, GWA, GWD, HA, HAB, HJA, HLS, HM, HMM, HRB, IM, JAC, JAG, JAH, JC, JCS, JGC, JH, JH-2, JJD, JLC, JLG, JLH, JM, JM-2, JME, JMP, JN, JP, JPW, JR, JRS, JTF, JTJ, KAF, KCO, KDE, KLA, KM, KS, LD, LEF, LEM, LES, LHR, LMB, LMG, LTH, MA, MAG, MAK, MAV, MC, MD, MDB, MG, MG-2, MH, MH-2, MJG, MLB, MLB-2, MLJ, MLW, MM, MM-2, MMV, MS, MSF, MSR, MW, NM, NYC, OD, PC, PEH, PSC, RA, RAD, RAG, RBK, RC, RC-2, RDS, RDW, RE, REB, RF, RJ, RL, RLC, RLE, RM, RPH, RR, RW, RWT, SAB, SC, SGM, SGV, SH, SHW, SJM, SM, SMC, SMC-2, SMG, SR, SSM, SW, SW-2, SW-3, TC, TD, TD-2,TDW, TJC, TK, TL, TLA, TLC, TLM, VDM, VF, VGR, VLM, WCS, WHG, WJB, WM, YMV and YMWDMH WRP Process Observation Monitoring Form 2. DMH WRP Process Observation Monitoring Form Instructions 3. PSH WRP Process Observation Monitoring summary data (May to October 2008) 4. DMH Clinical Chart Auditing Form 5. DMH Clinical Chart Auditing Form Instructions 6. PSH Clinical Chart Auditing Form summary data (May to October

		2008) 7. DMH WRP Substance Abuse Monitoring Form 8. DMH WRP Substance Abuse Monitoring Form Instructions 9. PSH Substance Abuse Monitoring summary data (May to October 2008) 10. PSH MAPP data regarding active treatment hours scheduled and attended (May to October 2008) 11. PSH Monthly MAPP Report 12. PSH data regarding Introduction to Wellness and Recovery and Medication Education groups (Mayo to October) 13. MSH and PSH Substance Abuse Treatment Program Plan of Improvement 14. PSH Implementation of the Substance Abuse Improvement Plan document 15. PSH Substance Abuse Training Program Examination 16. Completed Request for New Mall Group/Individual Therapy Forms 17. Credentialing/Privileging for Substance Abuse 18. List of individuals by Program by unit hours of Mall groups attended 19. List of individuals with cognitive disorders. 20. List of individuals with high Body Mass Index 21. List of individuals with Substance Abuse disorders. 22. List of new enrichment activities/groups offered over the last six months 23. List of new Mall groups 24. List of scheduled exercise groups 25. List of Staff needs for PSR Mall 26. List of Supplemental Activities Offered 27. List verifying competency for providing substance abuse groups 28. List verifying staff competency for specific mall groups 29. Mall Groups Hours Cancelled Report 30. Mall provider list 31. PSH Clinical Chart Auditing Form summary data (May 2008 t0 October 2008)

		32. PSH Course Outline: Substance Abuse Trans-theoretical Model (TTM) Skills Training 33. PSH Mall Lesson Plans (Focus 1 through Focus 11) 34. PSH MAPP data regarding active treatment hours scheduled and attended (November 2007 to April 2008) 35. Psychology Specialty Services Committee Minutes 36. Psychosocial Enrichment Activity List 37. Staff Development Attendance Sheet 38. Substance Abuse Facilitator Training List <u>Observed</u>: 1. WRPC (Program I, unit 5) for 14-day review of JC 2. WRPC (Program I, unit 74) for monthly review of HMC 3. WRPC (Program IV, unit 36) for monthly review of PAS 4. WRPC (Program IV, unit 37) for monthly review of TLZ 5. WRPC (Program V, unit 23) for quarterly review of AAM 6. WRPC (Program VI, unit 9) for 14-day review of EDR 7. WRPC (Program VI, unit 10) for monthly review of RA 8. WRPC (Program VI, unit 71) for 7-day review of KDK 9. WRPC (Program VI, unit 71) for 7-day review of MB 10. WRPC (Program VII, unit 76) for quarterly review of RB 11. WRPC (Program VIII, unit 21) for monthly review of LWM 12. WRPC (Program VIII, unit 25) for quarterly review of JAG 13. Pathways Intake to Orientation Mall Group 14. Court Preparation Mall Group 15. Stress Management Technique Mall Group 16. Fast Track PC 1370 Mall Group 17. Combined ETRC and PSSC Meeting 18. PSSC Meeting

C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to Mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Continue current training and mentoring regarding engagement of individuals. **Findings:** Since August 2008, PSH has provided training using the MSH Engagement module. The training was provided to WRPTs that were considered to be in need. The teams were selected based on three-month average scores on identified questions on the DMH WRP Chart Auditing and DMH WRP Observation Monitoring Forms. The facility recognized problems with regard to adequacy of referral numbers and follow-up on noncompliance with training. Data regarding the percentage of WRPT members who successfully completed this training and corrective actions to address the identified problems were presented in C.1.a. **Recommendations 2 and 3, June 2008:** • Monitor this requirement using process observation based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Observation Monitoring Form to assess compliance (March to August 2008). The average sample was 22% of all WRPCs due each month. The following is a summary of the data: 6. *Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to Mall* — 13%

	groups and therapies appropriate to their WRPs.	
6.a	*The WRPT asks the individual for his or her input into the evaluation of progress on each objective, as clinically indicated.*	28%
6.b	*When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups available for the next objective. The individual makes a choice from several equivalent options.*	6%
6.c	*The WRPT reviews the By Choice points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.*	30%
6.d	*When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.*	38%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.	2%	13%
Compliance rate in last month of period		
6.	5%	35%
6.a	7%	65%
6.b	0%	17%
6.c	24%	60%
6.d	24%	69%

		The facility reported that the lack of discussion with the individual regarding new Mall group options when an objective has been achieved was the main barrier to compliance. Other barriers included WRPTs' uncertainty regarding availability of openings in groups at the time of the WRPC. Corrective actions included the following: 1. Program-level analyses will be shared with the Clinical Administrator and Program Directors to assist in addressing disparities among programs and teams regarding compliance with this requirement. 2. Mentors will continue to assist their WRPTs in overcoming logistical barriers regarding use of the Mall catalog or identification of group availability. 3. WRPTs that continue to score low will be referred to Psychiatry seniors for supervisory oversight of the WRPT leader. **Recommendation 4, June 2008:** Implement corrective actions to resolve system barriers regarding review and revision of WRPs during the WRPC. **Findings:** PSH reported that corrective actions are underway through the introduction of MAPP-II, which is part of WaRMSS. The program is slated to be implemented in the summer of 2009. Pending implementation, PSH has initiated a number of adequate processes to improve the communication of PSR Mall group changes and schedules to WRPTs. **Other findings:** See this monitor's findings in C.1.a regarding the engagement of the

		individuals. **Compliance:** Partial. **Current recommendations**: 1. Continue current training and mentoring regarding engagement of individuals and present competency-based training data regarding engagement of the individuals. 2. Monitor this requirement using process observation based on at least 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendations 1-3, June 2008:** • Continue current practice. • Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period), as indicated. **Findings:** PSH used the DMH Chart Auditing Form to assess compliance with the requirements of C.2.b.i-C.2.b.iii (May to October 2008). Based on an average sample of 17% of the A-WRPs, the facility reported a mean

		compliance rate of 99% with this requirement (compared to 100% during the previous review). The facility's data are presented below in each corresponding cell (C.2.b.ii and C.2.b.iii). Corrective actions were the same as those outlined in C.1.a and C.2.a. **Other findings:** This monitor reviewed the charts of 10 individuals (AAC, DAR, EJM, ELF, JME, JN, LHR, MAK, MG and MH) who were admitted during this reporting period. This review found compliance in seven charts (AAC, DAR, EJM, JN, LHR, MG and MH) and noncompliance in three (ELF, JME and MAK). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using WRP Process Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the DMH Chart Auditing Form, based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period), as indicated.

		Findings: The facility reported a mean compliance rate of 98% for this requirement. However, the average sample was 5% of all master WRPs, a much decreased sample compared to the last review. The mean compliance rate for the past review period was 64%. **Recommendation 3, June 2008:** Implement plans to ensure that individuals remain on the admission units for 60 or more days prior to inter-unit transfers. **Findings:** In September 2008, PSH converted one non-admission unit to an admission unit in an effort to ensure that individuals remain on the admission units for at least 60 days prior to transfer. The facility reported that 59% and 71% of newly admitted individuals in September and October 2008 respectively remained on admission units for at least 60 days prior to transfer **Other findings:** Reviews by this monitor found compliance in all charts (AAC, DAR, EJM, ELF, JME, JN, LHR, MAK, MG and MH). **Compliance:** Substantial. **Current recommendations**: 1. Monitor this requirement using chart auditing based on at least 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). 3. Ensure that individuals remain on the admission units for 60 or more

		days prior to inter-unit transfers.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the twelfth monthly review is the annual review.	**Current findings on previous recommendations:** **Recommendations 1 and 2 June 2008:** • Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period), as indicated. **Findings:** The following is a summary of the facility's data:

WRP Review	Mean sample size	Mean compliance
14-Day	10%	90%
Monthly	11%	45%
Quarterly	12%	45%
Annual	14%	43%

Comparative data showed improvement in compliance since the last review as follows:

<u>14-Day Review</u>

	Previous period	Current period
Mean compliance rate		
3.	62%	90%

Monthly Review

	Previous period	Current period
Mean compliance rate		
3.	12%	45%
Compliance rate in last month of period		
3.	29%	44%

Quarterly Review

	Previous period	Current period
Mean compliance rate		
3.	6%	45%
Compliance rate in last month of period		
3.	19%	50%

Annual Review

	Previous period	Current period
Mean compliance rate		
3.	23%	43%
Compliance rate in last month of period		
3.	36%	40%

Other findings:
Chart reviews by this monitor found compliance in four charts (JM, LHR, MG and MH), partial compliance in five (AAC, ELF, JME, JN and MAK) and noncompliance in one (DAR).

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period), as indicated.
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Clinical Chart Auditing Form to assess compliance. However, the average sample of 2% was too small to permit meaningful review of the facility's data. PSH has implemented corrective administrative actions to address this issue. **Recommendation 3, June 2008:** Address and correct the specific deficiencies outlined by this monitor regarding the care of individuals diagnosed with cognitive impairments and seizure disorders. **Findings:** The facility reported that a DCAT team has been initiated and has begun working with the WRPTs in an effort to improve compliance with

		this requirement. **Other findings:** This monitor reviewed the charts of nine individuals diagnosed with a variety of cognitive disorders and seven individuals diagnosed with seizure disorders. The reviews found general evidence of some improvement in the following areas: 1. Documentation of foci, objectives and interventions that were aligned with the needs of some individuals diagnosed with seizure disorders; 2. Decreased use of regular treatment with anticholinergic and/or benzodiazepine medications for individuals suffering from dementing illnesses; 3. Documentation of the status of some individuals suffering from seizure disorders and dementing illnesses in the present status section of the case formulation; and 4. Development of learning-based objectives and interventions for some individuals suffering from seizure disorders, including recognizing and responding to the experience of an aura (JM) and/or learning about environmental triggers of recurrent seizures (JJD). However, the review also found a persistent pattern of deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies: 1. Individuals diagnosed with cognitive impairments (AAA, CL, END, IM, LEM, RC, SJM, TK and TLM): a. The WRP did not include a focus statement or objectives/ interventions to address diagnoses of Dementia NOS (AAA), Mild Mental Retardation (LEM and TK), Cognitive Disorder NOS vs. Substance-Induced Dementia (TLM) and Cognitive Disorder

		NOS (END). b. The WRP included appropriate focus and objective related to cognitive impairment in an individual diagnosed with Mild Mental Retardation (RC). However, the interventions were either unrelated to the stated objective or did not specify how the objective will be achieved. c. The WRP included an incomplete focus statement regarding a diagnosis of Dementia NOS (CL). d. The WRP included a focus statement regarding a diagnosis of Dementia NOS (IM). However, the objectives and interventions that were listed to address this condition did not relate to the cognitive impairment. e. The psychiatric progress notes did not address the assessment and management needs of individuals diagnosed with Cognitive Disorder NOS vs. Substance-Induced Dementia (TLM), Dementia NOS vs. Cognitive Disorder NOS (SJM) and Cognitive Disorder NOS (END). f. The WRP included objectives and interventions to address a diagnosis of Dementia NOS (CL). However, the first objective was inappropriate and the interventions did not address the cognitive impairment, including the need for specific group interventions. None of the interventions included cognitive remediation. A similar pattern was noted in the chart of SJM. g. There was inconsistency between the WRP and the corresponding psychiatric progress notes regarding the presence of a diagnosis of Dementia NOS (AAA) or Dementia NOS vs. Cognitive Disorder NOS (SJM). h. There was evidence of limited offerings of cognitive remediation groups to meet the needs of the relatively large number of individuals diagnosed with cognitive impairments in the facility. 2. Individuals diagnosed with seizure disorders (AKS, DFV, JJD, JM, NM, RDW and WJB):

		a. The WRPs did not specify the morphological diagnosis of the seizure disorder in all the charts reviewed. This information is needed to assess the match between anticonvulsant drugs and the individual's condition. b. One WRP did not include a diagnosis of seizure disorder or focus, objective and/or intervention related to seizure disorder in an individual receiving treatment with phenytoin as for seizure disorder (WJB). c. Some WRPs included the objective of remaining seizure-free, which is not attainable for the individuals (DFV). d. Some WRPs included generic objectives and interventions that addressed safety and compliance with treatment without justifying information (RDW). e. In all the charts reviewed, the WRPs failed to address the risks of treatment with older anticonvulsant medications, including their impact on the individual's behavior, cognitive status and quality of life. Some individuals (e.g. WJB) were also diagnosed with cognitive impairment, which increases the risks of this treatment. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary	**Compliance:** Partial.

	assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement the updated MSH modules regarding Case Formulation. **Findings:** As mentioned in C.1.a, the facility began implementation of the MSH module regarding Case Formulation in August 2008. **Recommendation 2, June 2008:** Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** The facility's data based on the DMH Clinical Chart Auditing Form are not presented because the average sample of 2% was too small for meaningful review. **Other findings:** Chart reviews by this monitor found that the present status section of the case formulation was much improved compared to the last review, including the review of symptoms, interventions and response, functional status, risk factors, progress towards discharge criteria, By Choice point allocation and medication side effects.

		However, the content of many formulations showed deficiencies that must be corrected to achieve substantial compliance. The following are examples: 1. In general, the present status sections did not include sufficient review and analysis of the use of restrictive interventions. 2. Some WRPTs did not use important clinical data that became available during the WRPCs to update the precipitating factors section. 3. Some of the discharge criteria that were listed in the present status sections were generic and not sufficiently individualized. 4. In general, there was inadequate linkage within the 6-p components of the case formulation and between the material in the case formulations and the individual's life goals and strengths as utilized in the objectives and interventions. **Current recommendations**: 1. Continue training on the Case Formulation Module for all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above. 2. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.d.ii	include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;	Same as above.
C.2.d.iii	consider biomedical, psychosocial, and psychoeducational factors, as clinically	Same as above.

	appropriate, for each category in § [III.B.4.b] above;	
C.2.d.iv	consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	Same as above.
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	Same as above.
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	Same as above.
C.2.e	The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** 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. **Recommendations 2 and 3, June 2008:** • Monitor this requirement using the WRP Chart Auditing Form based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low

		compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** As mentioned above, the facility's Clinical Chart Auditing data were based on a very limited sample. **Other findings:** A review of records of 38 individuals receiving Rehabilitation Therapy and Nutrition Services (including PSR Mall groups and direct treatment) (AGW, AJB, AKA, ALO, AMO, BD, CD, CH, DAH, DBM, DFV-2, DWL, ECA, GWD, HJA, HLS, JAC, JC, JCS, JLG, JM-2, JTF, KCO, KDE, KS, MAG, MLB-2, MM-2, PEH, PSC, RBK, RE, REB, SC, TC, TD-2, TLA and WCS) to assess compliance with C.2.e found one record in substantial compliance (RE), 19 records in partial compliance (AJB, AKA, BD, CD, DAH, DBM, DFV-2, DWL, HJA, JC, JCS, JTF, KDE, KS, PEH, RBK, REB, TLA and WCS) and 18 records (AGW, ALO, AMO, CH, ECA, GWD, HLS, JAC, JLG, JM-2, KCO, MAG, MLB-2, MM-2, PSC, SC, TC and TD-2) not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP. 2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Interventions are not consistently written as indicated by facility requirements and integrated into the WRP. A review of records for 40 individuals who had IA-RTS assessments and Rehabilitation Therapy focused assessments during the review period (AKK, BKP, BLG, CHF, CT, DB, DFV-2, DMZ, DS, EF, EJM-2, EWM, FLL, HAB, JAH, JH-2, JP, KCO, LMB, LMG, MAV, MDB, MG-2, MH-2, MJG, MMV, MSF, NYC, PC, RAD, RC-2, RE, RF, RLE, RM, SGM,

		SR, SSM, VDM and YMW) to assess compliance with C.2.e found 18 records in partial compliance (AKK, BLG, CHF, DB, DFV-2, DMZ, EWM, JAH, JH-2, JP, MAV, MG-2, MJG, MSF, NYC, RC-2, RM and SR) and 22 records not in compliance (BKP, CT, DS, EF, EJM-2, FLL, HAB, KCO, LMB, LMG, MDB, MH-2, MMV, PC, RAD, RE, RF, RLE, SGM, SSM, VDM and YMW). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable and integrated into the WRP. 2. Foci, objectives and interventions are not consistently aligned in the WRP. 3. Interventions are not consistently written as indicated by facility requirements and integrated into the WRP. A review of records for 50 individuals with completed Nutrition Care assessments across sub-types (AG, AMO, ANA, ATL, BDS, BLM, BM, BMS, BN, BRC, BRT, CAZ, CHF, CMJ, CY, DAD, DAR-2, DET, DLD, ELF-2, GCD, GWA, HM, HMM, JAG, JAH, JLC, JLH, JMP, JP, JPW, JRS, KLA [two assessments reviewed], LES, MLJ, MS, MSR, RA, RAG, RDS, RWT, SH, SHW, SMC-2, SMG, SR, SW-3, TDW, VGR and YMV) to assess compliance with C.2.e found 14 records in substantial compliance (AG, BLM, BM, BRT, CAZ, CMJ, GCD, HMM, KLA, MSR, RDS, SW-3, TDW and VGR), 28 records in partial compliance (AMO, ANA, ATL, BDS, BN, BRC, DAD, DAR-2, DET, DLD, GWA, HM, JAG, JP, JPW, JRS, KLA, MLJ, MS, RA, RAG, RWT, SH, SHW, SMC-2, SMG, SR and YMV) and nine records not in compliance (BMS, CHF, CY, ELF-2, JAH, JLC, JLH, JMP and LES). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. WRP Nutrition objectives are not consistently specific, behavioral, observable and measurable.

		2. WRP Nutrition foci, objectives and interventions are not included in the WRP. **Compliance:** Partial. **Current recommendations**: 1. Same as in C.2.c, C.2.f, C.2.g and C.2.o. 2. Monitor this requirement using the WRP Chart Auditing Form based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement the updated MSH training modules regarding Foci, Objectives and Interventions/Mall Integration. **Findings:** As mentioned in C.1.a, PSH implemented this training in August 2008.

Recommendations 2 and 3, June 2008:

- Monitor this requirement based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

Findings:

PSH used the DMH Chart Auditing Form to assess compliance with the requirements in C.2.f.i through C.2.f.v (May to October). The average sample was 11% of the quarterly and annual WRPs due each month. The following is a summary of the data for this requirement. The data for C.2.f.ii to C.2.f.v are presented in each corresponding cell below, with the sub-indicators identified as necessary. The facility's plan of correction was the same as that outlined in C.1.a and C.2.a.

5.	*The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individual's functioning) that builds on the individual's strengths and addresses the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.*	7%
5.a	*All objectives for Focus 1, 3, and 5 are linked to the individual's stage of change*	43%
5.b	*The individual's strengths are used in the interventions.*	14%
5.c	*There is documented rationale in the focus area if any focus of hospitalization does not have an objective or an intervention.*	14%

Comparative data showed modest improvement since the last review as follows:

	Previous period	Current period
Mean compliance rate		
5.	2%	7%
Compliance rate in last month of period		
5.	1%	10%
5.a	34%	48%
5.b	6%	22%

PSH also used the DMH WRP Observation Monitoring Form (May to October 2008) to assess compliance with this requirement. The average sample was 22% of the WRPCs each month. The following is a summary of the data:

7.	*The treatment plan includes the individual's strengths related to each enrichment, treatment, or rehabilitation objective.*	3%
7.a	*Strengths are identified and incorporated into the interventions offered.*	6%
7.b	*The strengths are related to each treatment, rehabilitation or enrichment objective.*	4%

Comparative data showed minor improvement since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	2%	3%
Compliance rate in last month of period		
7.	3%	10%
7.a	4%	20%

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<tr>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.b</td><td>3%</td><td>15%</td></tr>
</table>

Other findings:
This monitor reviewed the charts of six individuals to assess compliance (ELF, JME, JN, LHR, MC and MH). The review found compliance in one chart (MH), partial compliance in three (JME, LHR and MC) and noncompliance in two (ELF and JN).

Compliance:
Partial.

Current recommendations:
1. Continue training on the Modules regarding Foci/Objectives and Interventions/Mall Integration for all WRPTs and ensure that the training addresses the deficiencies outlined by this monitor above.
2. Monitor this requirement based on at least a 20% sample.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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<tr>
<td>C.2.f.ii</td>
<td>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);</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2008:
Same as in C.2.f.i.

Findings:
The facility's data regarding this requirement are summarized as follows:
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6.	*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.)*	35%
6.a	*There are specific groups or individual therapy linked to specific objectives that focus on treatment (e.g., treatment of a specific medical or psychiatric condition) and are provided in the PSR Mall.*	33%
6.b	*There are specific skills training and support groups identified in the interventions that are linked to specific objectives and are provided in the PSR Mall.*	79%
6.c	*There are specific leisure and recreation groups specified in the interventions that are linked to objective derived to focus 10.*	39%

Comparative data showed improvement since the last review as follows, with the exception of item 6.b:

	Previous period	Current period
Mean compliance rate		
6.	14%	35%
Compliance rate in last month of period		
6.	25%	51%
6.a	7%	71%
6.b	82%	70%
6.c	26%	65%

Other findings:
Reviews by this monitor found compliance in four charts (JME, LHR, MC and MH) and noncompliance in two (ELF and JN).

		Compliance: Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 13% compared to 7% during the last review. The rate for the last month of this period was 23%, compared 4% in the last month of the previous review period. **Other findings:** Reviews by this monitor found partial compliance in five charts (ELF, JME, LHR, MC and MH) and noncompliance in one (JN). **Compliance:** Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in C.2.f.i.

		Findings: The facility reported a mean compliance rate of 58% compared to 29% during the last review. The rate for the last month of this period increased to 77% from 55% in the last month of the previous review period. **Other findings:** This monitor found compliance in one chart (JME), partial compliance in one (ELF) and noncompliance in four charts (JN, LHR, MC and MH). **Compliance:** Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in C.2.f.i. **Findings:** The facility reported a mean compliance rate of 27% compared to 7% during the last review. The rate for the last month of this period increased to 49% from 10% in the last month of the previous review period. **Other findings:** This monitor found compliance in three charts (ELF, MC and MH) and partial compliance in three (JME, JN and LHR). **Compliance:** Partial.

<table>
<tr><td></td><td></td><td>Current recommendations:
Same as in C.2.f.i.</td></tr>
<tr><td>C.2.f.vi</td><td>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;</td><td>Current findings on previous recommendations:

Recommendation 1, June 2008:
Continue to monitor hours of active treatment (scheduled and attended) and provide data analysis and corrective actions to ensure that individuals attend the required hours.

Findings:
PSH's data (May to October 2008) are summarized as follows :

<table>
<tr><td></td><td colspan="2">Number of individuals by category</td></tr>
<tr><td></td><td>Mean scheduled hours</td><td>Mean attended hours</td></tr>
<tr><td>N</td><td>1,530</td><td>1,530</td></tr>
<tr><td>Hours:</td><td></td><td></td></tr>
<tr><td>0-5</td><td>19</td><td>79</td></tr>
<tr><td>6-10</td><td>27</td><td>227</td></tr>
<tr><td>11-15</td><td>200</td><td>536</td></tr>
<tr><td>16-20</td><td>1,285</td><td>689</td></tr>
</table>

Comparative data showed that the average number of required scheduled and attended hours have decreased somewhat since the last review. The facility attributed this decrease to lack of timely notification of the WRPTs regarding transition to newly created Mall groups and shortage of facilitator hours due to required training and other duties. As corrective action, the facility plans to improve the notification of the WRPTs regarding Mall groups, and to ensure that facilitators are not redirected to other activities and that rehabilitation therapists and psychologists provide minimum required Mall hours (15 and 10 respectively).</td></tr>
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Recommendation 2, June 2008:
Ensure that the same groups are not counted more than once in the calculation of active treatment hours attended by the individuals.

Findings:
PSH reported that some WRPs may continue to show the same group under multiple foci. However, the current MAPP electronic system does not count these groups more than once. The WRP Mentors continue to educate staff that groups may only be assigned for one focus of treatment.

Other findings:
This monitor reviewed the charts of six individuals (ELF, JME, JN, LHR, MC and MH). The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and attended. The reviews found that the individuals attended 10 or fewer hours of active treatment in most of the charts. In two charts, there was evidence of significant discrepancy between the WRPs and MAPP data regarding the number of scheduled hours. The following is an outline of the monitor's findings:

Individual	WRP scheduled	MAPP scheduled	MAPP attended
ELF	1	20	10
JME	22	20	7
JN	0	20	17
LHR	17	20	13
MC	19	20	6
MH	18	20	9

Compliance:
Partial.

		Current recommendations: 1. Monitor hours of active treatment (scheduled and attended). 2. Present data regarding average number of scheduled and attended hours (previous period and last month of previous period compared to current period and last month of current period). 3. Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.
C.2.f.vii	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	PSH is legally unable to allow individuals to participate in community treatment opportunities unless accompanied by a CDCR Correctional Officer. This is based on California Welfare and Institutions Code Section 4107(a), which requires that the security of individuals at Patton State Hospital is the responsibility of the Department of Corrections and Rehabilitation. At the present time PSH has approximately 109 civil individuals who have been determined to exceed the security levels of either Napa State Hospital and/or Metropolitan State Hospital. These individuals have been identified by history to be high risk to the safety and security of the public if they were to elope during community outings. The facility will explore what barriers exist for CDCR to provide/coordinate security supervision to facilitate community treatment opportunities.
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to Mall	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the Mall Alignment Monitoring Form. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

	groups that link directly to the objectives in the individual's WRP and needs.	**Findings:** PSH used the DMH Mall Alignment Monitoring Form to assess compliance (May to October 2008). Based on a target population of 20 individuals, the average sample was 23 individuals. The facility did not present data on the two sub-items of the main indicator. The mean compliance rate for the indicator was 9% compared to 44% during the last review. The rate for the last month of this review period was 0% compared to 32% during the last month of the previous review period. The facility attributed its low compliance to the small target population due to the time required to complete this audit and the fact that the auditing question required that only one intervention per focus be reviewed for linkage. This tool was revised in November 2008 to address these concerns. **Recommendation 3, June 2008:** Implement electronic progress note documentation by all Mall and individual therapy providers and ensure integration of data, as needed, into the WRPs. **Findings:** The DMH has completed the business rules for the PSR Mall Note module of MAPP II. Implementation is expected in summer 2009. **Other findings:** Reviews by this monitor found compliance in one chart (MH), partial compliance in three (JME, MC and LHR), and noncompliance in two. The current format of the Mall Facilitator Progress Note does not provide the information needed to adequately inform the review and revision of the WRP. The DMH has revised this format, which provided needed correction. The revised format has yet to be implemented.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the Mall Alignment Monitoring Form and present data on the main indicator and the two sub-items. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement the revised DMH Mall Facilitator Progress Notes and track the completion of these notes and the integration of information into the WRPs.
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the Clinical Chart Auditing and the WRP Process Observation Monitoring forms, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Clinical Chart Auditing and WRP Observation

Monitoring Forms to assess compliance with this requirement (May to October 2008). The clinical chart auditing data are not presented in this report because the sample size was too small. The observation monitoring data were based on an average sample of 11%. The following is a summary of these data:

8.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed 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.*	10%
8.a	*When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	30%
8.b	*When an individual has not shown progress on an objective for two months, the team revises or develops a new objective or a new intervention.*	11%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	3%	10%
Compliance rate in last month of period		
8.	5%	28%
8.a	6%	27%
8.b	8%	22%

The facility's corrective actions were essentially the same as those outlined in C.1.a and C.2.a.

		Recommendation 3, June 2008: Resolve systemic barriers contributing to low compliance. **Findings:** PSH reported that the recent introduction of the modified format for the monthly WRPC has enabled the teams to prioritize the individual's needs, thus allowing sufficient time and attention to revise the WRP as needed. **Other findings:** Reviews by this monitor found compliance in two charts (ELF and LHR) and non-compliance in four (JME, JN, MC and MH). A review of records of 14 individuals receiving direct Occupational, Physical and Speech Therapy services (AGW, AJB, AKA, CH, DAH, DFV-2, DWL, HLS, JAC, KCO, MM-2, PSC, TC and TLA) found 12 records in compliance (AGW, AJB, AKA, DFV-2, DWL, HLS, JAC, KCO, MM-2, PSC, TC and TLA) and two records not in compliance (CH and DAH). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using Clinical Chart Auditing and the WRP Process Observation Monitoring forms, based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Continue implementation of the modified format for the monthly WRPC and ensure timely and appropriate revisions of the WRPs, as clinically indicated.

C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Chart Auditing Form to assess compliance (March to August 2008), based on average sample of 11% of the Quarterly and Annual WRPs per month. The mean compliance rate was 36% compared to 8% during the last review. The rate for the last month of this period was 29% compared to 33% for the last month of the previous review period. PSH also used the DMH WRP Observation Monitoring Form to assess compliance. The following is a summary of the observation monitoring data:

9.	*The team revised the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and developed 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.*	38%
9.a	*When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	42%
9.b	*When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.*	14%

Comparative data showed mixed changes in compliance rates since the last review as follows:

	Previous period	Current period
Mean compliance rate		
9.	11%	38%
Compliance rate in last month of period		
9.	19%	49%
9.a	27%	53%
9.b	2%	35%

The facility's corrective actions were essentially the same as those outlined in C.1.a and C.2.a.

Other findings:
This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period (ANM, CCS, HRB, LEF, SAB and VLM). The review focused on the documentation in the present status section of the circumstances leading to the use of restrictive intervention, treatment provided to avert the use of the interventions and modifications of treatment to decrease the risk of future occurrences. The review found partial compliance in all charts reviewed.

The main deficiencies involved lack of adequate documentation of the following:

1. Circumstances that required the use of restrictive interventions (in specific terms);
2. Treatment provided to avert the use of restrictive intervention (in specific terms);

		3. Modification of ongoing treatment to decrease future risk; and 4. Assessment of risk factors in the present status section, particularly regarding dangerousness to others. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement corrective actions to ensure: a. Review by the WRPTs of the circumstances related to the use of restrictive interventions; and b. Timely and appropriate modification of the WRPs in response to the review. 2. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH monitored this requirement using the DMH WRP Observation Monitoring and DMH Discharge Planning and Community Integration Form (see E.3) Forms. These mechanisms are sufficient to assess compliance with this requirement. The following is a summary of the

facility's process observation data:

10.	*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.*	23%
10.a	*The team reviews all Foci that are barriers to discharge.*	39%
10.b	*The team reviews the PSR Mall Facilitator's Monthly Notes for all objectives related to discharge.*	18%

The mean compliance rate for item10 appears to be in error given the compliance rate for sub-item 10.b.

Comparative data showed improvement in compliance rates since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.	3%	23%
Compliance rate in last month of period		
10.	3%	44%
10.a	22%	65%
10.b	1%	46%

The facility's corrective actions were essentially the same as those outlined in C.1.a and C.2.a.

Recommendation 3, June 2008:
Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their

		discussion of progress towards discharge criteria. **Findings:** As mentioned in C.1.a, PSH has begun implementation of the MSH training module regarding Discharge Planning. **Other findings:** This monitor reviewed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the present status section of the case formulation). The review found compliance in one chart (ELF), partial compliance in four (JME, JN, LHR and MH) and noncompliance in one (MC). The review found evidence of some improvement in the review of the individual's progress towards each discharge criterion as documented in the present status section of the case formulation. However, the review found persistent deficiencies involving the facility's documentation of some discharge criteria that were generic, not measurable and not sufficiently individualized. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using process observation in this section and DMH Discharge Planning and Community Integration Form in section E.3 based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.

C.2.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, June 2008:** Same as in C.2.g.i. **Findings:** Same as in C.2.g.i. **Recommendation 2, June 2008:** Same as in C.2.f.viii. **Findings:** Same as in C.2.f.viii. **Other findings:** The following is a summary of the facility's process observation data:

11	*Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.*	13%
11.a	*The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.*	15%
11.b	*Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.*	6%

Comparative data showed improvement in compliance rates since the last review as follows:

	Previous period	Current period

Mean compliance rate		
11.	0%	13%
Compliance rate in last month of period		
11.	0%	37%
11.a	1%	39%
11.b	1%	24%

The facility's corrective actions were essentially the same as those outlined in C.1.a and C.2.a.

Reviews by this monitor found partial compliance in one chart (MH) and noncompliance in five charts (ELF, JME, JN, LHR and MC). The main deficiencies were as follows:

1. The Mall notes were not completed and filed in a timely manner;
2. The current format of the Mall notes did not provide information needed to guide the revisions of the WRP.
3. The team's review of the notes and integration and utilization of this review to inform revisions of the WRP were either missing or inadequate.

As mentioned earlier, the facility has yet to implement the DMH revised format of the Mall progress notes. If properly implemented, this format provides sufficient information to guide the WRP reviews/revisions.

Compliance:
Partial.

Current recommendations:
1. Same as in C.2.g.i.
2. Same as in C.2.f.viii.

C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	Please see F.2.a through F.2.c (including sub-cells) for PBS-related recommendations.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Recommendation 1, June 2008:** WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. **Findings:** This monitor reviewed five charts (EM, MA, MD, MW and RJ) Two of the five WRPs in the charts (MA and RJ) had integrated the relevant information from the discipline-specific assessments into the relevant sections of the individual's WRP, and three of them had not (EM, MD, and MW). **Recommendation 2, June 2008:** Continue to offer groups based on the needs of the individuals in the facility. **Findings:** Using item 2 from the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on a mean sample of 20 randomly selected WRPs due for the month (May to October 2008). The table below with its indicators and sub-indicators and corresponding mean compliance is a summary of the data: 2. *Is based on the individual's assessed needs and is directed toward increasing the individual's ability to* — 20%

	engage in more independent life functions	
2.a	*All Mall courses listed in the individual's schedule are listed as interventions in the individual's WRP*	24%
2.b	*The course outlines of all those courses include a rationale for how the Mall course is aimed at improving the individual's independent life functioning*	30%

Comparative data showed a decline in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	45%	20%
Compliance rate in last month of period		
2.	42%	12%
2.a	42%	12%
2.b	42%	19%

As the tables above show, there is a significant discrepancy between the Mall schedule and the entries of Mall groups in the individuals' intervention section of the WRP, and a large number of individuals were not receiving optimal PSR services based on their assessed needs.

This monitor's findings from review of five charts (JGC, KAF, KED, SMG and WC) are in agreement with the facility's data. In three of the five WRPs in the charts (KAF, SMG and WC), the Mall groups in the interventions sections were not aligned with the individual's Mall schedule and/or the services offered were not optimal for the individual to develop greater independence by learning the necessary skills and supports.

		As plan of correction, the Mall Director is working on having objectives written for all Mall courses, plans to incorporate PSR Mall Data Variables from discipline-specific assessments to align the needs of the individual to what is being offered in the Mall groups, and has set up Group Activity Request Forms (both for requests from WRPTs and the individuals themselves). PSH also has initiated an integrated weight management program, which is at the pilot stage. **Other findings:** A review of records of 34 individuals receiving Rehabilitation Therapy and Nutrition Services (including PSR Mall groups and direct treatment) (AGW, AJB, AKA, ALO, AMO, BD, CD, DAH, DBM, DFV-2, ECA, GWD, HJA, HLS, JC, JCS, JLG, JM-2, JTF, KCO, KDE, KS, MAG, MLB-2, MM-2, PEH, PSC, RBK, RE, REB, SC, TD-2, TLA and WCS)to assess compliance with C.2.i.i found 33 records in compliance(AGW, AJB, AKA, ALO, AMO, BD, CD, DAH, DBM, DFV-2, ECA, HJA, HLS, JC, JCS, JLG, JM-2, JTF, KCO, KDE, KS, MAG, MLB-2, MM-2, PEH, PSC, RBK, RE, REB, SC, TD-2, TLA and WCS) and one record not in compliance (GWD). **Current recommendations**: 1. WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 2. Continue to offer groups based on the needs of the individuals in the facility.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that the learning outcomes are stated in measurable terms. **Findings:** Using item 7 from the DMH WRP Chart Auditing Form, PSH assessed its compliance based on observation of an average sample of 11% of the

WRPs due for the month (May to October 2008). The table below is a summary of the data:

7.	*The WRP plan includes behavioral, observable, and/or measurable objectives written in terms of what the individual will do.*	13%

Comparative data showed modest improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	7%	13%
Compliance rate in last month of period		
7.	4%	23%

As the data in the tables above show, WRPT members continue to have difficulty formulating objectives in an observable/measurable term.

This monitor reviewed 14 charts (AH, AM, EM, GA, HA, JR, MA, MD, MM, RJ, RLC, SM, SW and SW-2). Nine of the WRPs in the charts (AM, EM, GA, HA, MA, MD, RJ, SM and SW) had their learning outcomes stated in measurable terms. The remaining five (AH, JR, MM, RLC and SW-2) did not have one or more of their learning outcomes written measurable terms.

As plan of correction, PSH plans to continue to train and mentor its WRPTs.

Recommendations 2 and 3, June 2008:

- Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria.

		• Ensure that the courses offered have individualized objectives, observable outcomes, and evaluation measures for all individuals attending the course. **Findings:** This monitor reviewed 11 charts (AH, AM, EM, GA, MA, MD, MM, RJ, RLC, SM and SW). Eight of the WRPs in the charts (AM, EM, GA, MA, MD, RJ, SM and SW) addressed the necessary discharge criteria with a relevant focus and an aligned objective for each focus. The remaining three (AH, MM, and RLC) did not. All Mall courses offered at PSH do not have individualized objectives, observable outcomes, and evaluation measures for all individuals attending the course. A review of the Mall courses and information from the Mall Director found that PSH has written curriculums and lesson plans for 95% of the Mall groups. Only 34% of the groups have fully developed objectives, outcomes, and evaluation measures for individuals attending the groups. Review of the Monthly Mall Progress Notes and reports from Mall Facilitators indicated that individuals' objectives and outcomes are not tracked and reported on a consistent basis. The Mall Director intends to see that course objectives, outcomes, and evaluation measures are developed for all Mall courses, improve the process and quality of the Monthly Mall Progress Notes, and work with the Mall Facilitators **Current recommendations**: 1. Ensure that the learning outcomes are stated in measurable terms. 2. Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria. 3. Ensure that the courses teach to individualized objectives and include evaluation measures for all individuals attending the course.

C.2.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, June 2008:** Ensure that WRPTs write objectives in behavioral, observable, and/or measurable terms. **Findings:** Same as C.2.i.ii. **Recommendation 2, June 2008:** Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals. **Findings:** Using item 4 from the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on observation of a randomly chosen 20 WRPs due for the month (May to October 2008). The table below is a summary of the data:

4.	*Is aligned with the individual's objectives that are identified in the individual's wellness and recovery plan.*	13%

Comparative data showed a decline in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
4.	41%	13%
Compliance rate in last month of period		
4.	0%	12%

This monitor reviewed six charts (CW, JGC, KAF, KED, MW and SMG). Mall therapies and services provided for KED were mostly aligned with the individual's foci, objectives, interventions, and the Mall schedule and Mall groups. The remaining five had missing elements, inconsistencies, or insufficient Mall groups and therapies to fully meet the individual's needs.

Recommendation 3, June 2008:
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:
Using item 11 from the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on observation of an average sample of 11% of the WRPCs due for the month (May to October 2008). The table below is a summary of the data:

11.	*Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.*	13%
11.a	*The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.*	15%
11.b	*Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.*	6%

Comparative data showed some improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
11.	0%	13%
Compliance rate in last month of period		
11.a	0%	37%
11.b	1%	39%
11.c	1%	24%

PSH's volume of written Monthly Mall Progress Notes has increased since the last review period. However, the overall mean compliance regarding notes written is still low. This monitor reviewed a sample of the monthly Mall progress notes written by Mall facilitators for nine individuals (GC, JH, LD, MM, RL, RW, TD, VF and WM). Four of the notes (GC, LD, TD and VF) were complete and informative. In the remaining cases, the notes were blank, incomplete, or lacked useful information for WRPTs to address the individual's progress or lack thereof, and to modify their objectives/interventions.

As corrective actions, PSH plans to fully automate the PSR Mall note system, conduct monthly audits, and have its Seniors/supervisors monitor facilitator completion of the PSR Mall Notes.

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. 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.

C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP, in accordance with the DMH WRP manual. **Findings:** This monitor reviewed 13 charts (AH, AM, EM, GA, HA, JR, MA, MD, MM, RJ, RLC, SM and SW). Three of the WRPs in the charts (GA, JR and MA) had strengths identified in all the interventions. The remaining ten WRPs (AH, AM, EM, HA, MD, MM, RJ, RLC, SM and SW) did not identify strengths in all the interventions. **Recommendation 2, June 2008:** Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services. **Findings:** Using item 6 (*Utilizes the individual's strengths, preferences and interests*) from the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on an average random sample of 20 individuals for each month (May to October 2008), reporting 8% compliance. The table below showing the census for the month (N), the number of individuals audited for the month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	5-08	6-08	7-08	8-08	9-08	10-08	Mean
N	1491	1498	1503	1501	1496	1509	
n	21	18	25	21	27	26	
%C	10	10	8	5	0	15	8

Comparative data showed a decline in mean compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.	18%	8%
Compliance rate in last month of period		
6.	0%	15%

This monitor's review of WRPs and Mall progress notes (GC, JH, LD, MM, RL, RW, TD, VF and WM), observation of Mall groups (Pathways Intake To Orientation Mall Group, Court Preparation Mall Group, Stress Management Technique Mall Group, and Fast Track PC 1370 Mall Group) and interview of Mall facilitators and the Mall Director found that group facilitators and individual therapists do not always know the strengths, preferences and interests of the individuals attending their PSR services. Facilitators are familiar with the strengths, preferences and interests of the individuals for whom they are on the WRPT, but not otherwise. A few facilitators who are not part of the individual's WRPT take the initiative to look up the information in the individual's chart; however, in some cases even this is not possible because WRPs do not always include appropriate strengths of the individuals in the intervention sections (for example MD, MM, MN, RJ and RLC).

Current recommendations:

1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP, in accordance with the DMH WRP manual.
2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services.

C.2.i.v	focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. **Findings:** This monitor observed three WRPCs (JC, KDK and MB). In all three cases, the teams functioned in an interdisciplinary manner. The core team members shared relevant information with the other team members and with the individual. **Recommendations 2 and 3, June 2008:** • Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. • Update the present status to reflect the current status of these vulnerabilities. **Findings:** Using item 6 from the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on observation on an average random sample of 20 WRPs for each month (May to October 2008). The table below is a summary of the data: 6. *Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.* 33% 6.a *The interventions are aligned with the listed foci and objectives.* 46% 6.b *The individual is currently in or has completed a WRAP group that focuses on discharge barriers.* 41% Comparative data showed a decline in compliance since the last review

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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>64%</td><td>33%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>53%</td><td>19%</td></tr>
<tr><td>6.a</td><td>53%</td><td>19%</td></tr>
<tr><td>6.b</td><td>63%</td><td>23%</td></tr>
</table>
This monitor reviewed 10 charts (AH, AM, EM, GA, MA, MD, MM, RJ, RLC and SW). Three of the WRPs in the charts (GA, MA and SW) described the individual's vulnerabilities in the case formulation under the 6-Ps, and updated the present status to reflect the current status of these vulnerabilities. The remaining seven (AH, AM, EM, MD, MM, RJ and RLC) did not fully discuss the individual's vulnerabilities and/or update them to reflect the current status of these vulnerabilities.

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.
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<tr>
<td>C.2.i.vi</td>
<td>is provided in a manner consistent with each individual's cognitive strengths and limitations;</td>
<td>**Current findings on previous recommendations:**

Recommendation 1, June 2008:
PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group.</td>
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Findings:
Using item 7 from the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on observation of an average random sample of 20 individuals for each month (May to October 2008). The table below is a summary of the data:

7.	*Is provided in a manner consistent with each individual's cognitive strengths and limitations.*	24%
7.a	*The course outlines for the WRP assigned Mall courses are noted as being appropriate for the individual given his cognitive level.*	33%
7.b	*The Mall course facilitator interviewed could state the individual's cognitive strengths and limitations, and at least one method of teaching at that level.*	35%

Comparative data were not available for item 7.

PSH is not addressing the assessed cognitive levels of all individuals in all the Mall groups. Documentation review and interview of the Mall Director found that PSH currently has eight cognitive remediation Mall groups and 96 Mall groups that address individuals' cognitive limitations. Cognitive screening of all individuals is conducted as part of the Integrated Assessment: Psychology Section when an individual is admitted to PSH, and cognitive strengths and limitations are also assessed in the Substance Abuse groups. A review of Mall courses indicate that most of the courses indicate suitability regarding cognition level. PSH also has introduced a number of Mall groups have for individuals with specific cognitive levels. However, not all individuals have their assigned Mall groups matched to their cognitive levels. Observation of Mall groups found that in a number of groups, the participants were heterogeneous and the instructors did not use appropriate methodology (language and/or activities) for individuals with varying cognitive levels. Some groups were large (groups were

		combined due to unavailability of providers), making it difficult for providers to address the group process and use procedures suitable for the individuals' cognitive levels. As corrective action, PSH plans to increase the number of Mall groups until the cognitive levels of all individuals in the facility are addressed, and increase the number of facilitators trained in conducting cognitive remediation groups. **Recommendation 2, June 2008:** 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 at the present time. According to the Chief of Psychology, PSH recently hired one DCAT team member (Psychologist) who has not been trained in DCAT matters, and a Social Work candidate and a PT candidate were interviewed in November 2008). The remaining positions (Data Analyst/Behavior Specialist and Registered Nurse) are not allocated. **Current recommendations**: 1. PSR Mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. 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.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendations 1-3, June 2008:** • Ensure that WRPTs receive timely progress notes on individuals'

participation in their psychosocial rehabilitation services.

- Automate this system.
- Use the data from the PSR Mall Facilitator Monthly Progress Notes in the WRP review process.

Findings:

This monitor's interview of the Director of Standards Compliance and the Mall Director found that PSH's Mall progress note system is not fully automated.

PSH audited 20% of the individuals in each Program for the last month of the review period, reporting mean compliance of 15%. The table below showing the number of Progress Notes due for 20% of the individuals in the program (N), the number of Progress Notes available to the WRPTs in each Program (n), and the percentage of compliance (%C) is a summary of the facility's data.

	P1	P3	P4	P5	P6	P7	P8	Mean
N	880	780	780	800	1,200	780	780	
n	92	81	125	103	44	22	457	
%C	10	10	16	13	4	3	59	15

As the table above shows, timely completed Monthly Progress Notes are few and far in between. The system needs to be fully automated for this procedure to be functional.

This monitor reviewed 13 charts (AH, AM, EM, GA, HA, JR, MA, MD, MM, RJ, RLC, SM and SW). Three of them (AM, MA and RJ) contained Monthly Progress Notes, and the notes were used in the WRP review process. However, the notes did not include sufficient information on the individual's progress towards his/her objectives for the WRPTs to evaluate the progress and make necessary changes. The remaining ten charts (AH, EM, GA, HA, JR, MD, MM, RLC, SM and SW) did not have

		the required Monthly Mall Progress Notes. As corrective action, PSH plans on automating the Monthly Progress Notes system, increasing the number of staff hours allocated toward processing PSR Mall notes, conducting monthly audits, and having Seniors/supervisors monitor Mall Notes completion. **Other findings:** A review of records of 37 individuals receiving Rehabilitation Therapy and Nutrition Services (including PSR Mall groups and direct treatment) (AJB, AKA, ALO, AMO, BD, CD, CH, DAH, DBM, DFV-2, DWL, ECA, GWD, HJA, HLS, JAC, JC, JCS, JLG, JM-2, JTF, KCO, KDE, KS, MAG, MLB-2, MM-2, PEH, PSC, RBK, RE, REB, SC, TC, TD-2, TLA and WCS) to assess compliance with C.2.i.vii found two records in compliance (DWL and TC) and 35 records not in compliance (AJB, AKA, ALO, AMO, BD, CD, CH, DAH, DBM, DFV-2, ECA, GWD, HJA, HLS, JAC, JC, JCS, JLG, JM-2, JTF, KCO, KDE, KS, MAG, MLB-2, MM-2, PEH, PSC, RBK, RE, REB, SC, TD-2, TLA and WCS). **Current recommendations**: 1. Ensure that WRPTs 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.
C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** 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: This monitor's interview of the Mall Director found that PSH has yet to formally mandate that all staff, other than those who provide emergency services, provide services during Mall hours. PSH's Mall group functioning continues to suffer from provider shortage. As such, groups are combined, which adversely affects the facilitators' ability to conduct meaningful groups, or groups are cancelled, which deprives individuals of the needed services. **Recommendation 2, June 2008:** 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:** This monitor's documentation review (Mall schedules, By Choice point cards, and group rosters), interviews (individuals and Mall group facilitators) and observation of Mall groups found that in most cases Mall sessions were scheduled and conducted for 50 minutes each. PSH's data showed that the number of groups conducted for 50 minutes had increased from an average 68% in the last review period to an average 84% during this review period. According to the Mall Director, security issues, ambulance arrivals, and delay in Mall transitions due to non-availability of providers are some of the reasons for Mall groups not being conducted for the full 50 minutes. As corrective action, PSH plans to minimize/eliminate factors that delay Mall transition, have Program Management oversee preparation of units for timely transition to Mall groups, increase facilitator hours available to provide coverage for Mall groups, and have seniors/supervisors arrange for facilitators to be on time to Mall groups.

Recommendation 3, June 2008:
Ensure that individuals participate in their scheduled hours.

Findings:
The table below showing the facility's census for the month (N), the category of hours, and the number of individuals participating at each category is a summary of the facility's audit data regarding individuals' average weekly Mall participation:

	5/08	6/08	7/08	8/08	9/08	10/08	Mean
N	1,525	1,523	1,523	1,522	1,543	1,548	1,530
0-5 hrs/wk	55	59	62	61	93	146	79
6-10 hrs/wk	194	148	191	183	295	353	227
11-15 hrs/wk	539	473	513	493	693	502	536
16-20+ hrs/wk	737	843	757	785	462	547	689

Comparative data showed mixed changes since the last review as follows

	Previous period	Current period
Mean attendance (number of individuals)		
0-5	55	79
6- 10	178	227
11-15	625	536
16-20+	655	689

	Previous period	Current period
Attendance in last month of period (number of individuals)		
0-5	78	146
6- 10	177	353
11-15	646	502
16-20+	636	547

According to the Mall Director, attendance declined in September and October 2008 due to increase in Mall closures owing to non-availability of Mall facilitators. Reasons offered, besides facilitators not going to their groups was that Mall facilitator attended required training sessions (the training sessions were held during Mall hours), and some of them were directed to other duties.

As plan of correction, newly hired staff is to provide the required number of Mall hours, rehabilitation therapists and psychologists are expected to provide their required Mall hours, and the administration is to intervene when group facilitators are directed to competing activities.

Recommendation 4, June 2008:
Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified.

Findings:
According to the Mall Director, WRPTs continue to use the Group Activity Request Forms when group needs are identified. PSH also has instituted Individual Request Forms (individuals can request new groups. The Mall Director reviews the request with the WRPT and where appropriate establishes a Mall group). Many of the requests are difficult to fulfill given that the Mall Director does not have sufficient

		facilitators even to consistently carry out the existing groups. **Current recommendations**: 1. 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. 2. All Mall sessions must be 50 minutes in length. Sessions less than that duration do not contribute to an individual's active treatment hours. 3. Ensure that individuals participate in their scheduled hours. 4. Provide groups as needed by the individuals and written in the individuals' WRPs, adding new groups as needs are identified.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendations:** **Recommendations 1 and 2,June 2008:** • 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. • 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 did not have any bed-bound individuals during this review period. However, PSH has a plan to implement the Mall group activities at the bedside or in an area within the individual's unit when bed-bound individuals are admitted. **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.
C.2.i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. **Findings:** Documentation review and interview of the Mall Director found that PSH has 96 groups for individuals with cognitive limitations under foci 1, 2, 3, 5, and 7, and 58 groups addressing medical risks. Nursing staff group facilitators now possess comprehensive lesson plans for medication education groups. Recreational groups have increased in number. Exercise groups are offered at three intensity levels. There is an increase in the number of discharge planning and community integration groups, and all the groups have lesson plans. PSH also has developed lesson plans for 95% of the Mall groups with outcome measures for 34% of these groups. **Recommendation 2, June 2008:** Ensure that Mall groups and individual therapies are cancelled rarely, if ever. **Findings:** This monitor's review of PSH's Mall cancellation data found that on average, 11% of scheduled Mall groups were cancelled in the last six

months. The table below showing the number of scheduled groups per month (N), the number of groups cancelled (n), and the percentage of scheduled groups that were held (%C) is a summary of the facility's data:

	5/08	6/08	7/08	8/08	9/08	10/08	Mean
N	1,631	1,686	1,644	1,672	1,698	1,593	
n	164	112	134	127	315	233	
%C	90	93	92	92	81	85	89

Comparative data showed improvement in compliance. The mean Mall cancellation rate for the previous period was 24% compared to 11% in this review period.

Reasons given for the cancellations included staff holidays, required staff education/training, and staff assignment to competing activities.

As plan of correction, PSH will ensure that WRPTs do not hold back WRPT members from facilitating scheduled Mall groups when the WRPC is not completed on time, increase facilitator hours to the required minimum, conduct trainings and meetings outside of Mall hours, and intervene when facilitators are redirected to other activities.

Recommendation 3, June 2008:
Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.

Findings:
PSH did not submit quantitative data showing the actual number of hours facilitated by each provider by discipline. According to the Mall Director, all disciplines are short on hours of service provided. The Mall Director also indicated that newly hired rehabilitation therapists, psychologists and social workers have increased the available number of

		facilitation hours. PSH needs to allot the necessary hours for each facilitator to meet the required hours per discipline and ensure that the facilitators consistently fulfill their required hours of facilitation As plan of correction, PSH will have the non-admission psychologists and rehabilitation therapists facilitate their minimum Mall hours (10 and 15 hours respectively), dedicate residential units to Mall services during Mall hours, engage all non-emergency staff in Mall group facilitation and increase the number of administrative and support staff facilitating the required one hour of Mall group per 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.
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Current findings on previous recommendations:** **Recommendations 1-4, June 2008:** • 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. • Plan and organize these activities such that there is minimal interruption, individuals are reinforced to participate regularly in these activities, and as much as possible eliminate competing activities that act as a barrier for individuals to participate in such activities. • Increase the number of hours of enrichment activities per individual provided in the evenings and weekends.

- Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.

Findings:
PSH presented a list of enrichment activities with names of staff facilitating the activities. The activities are organized and managed at the unit level. Individuals have many choices of activities and there are no interruptions to individuals' participation except for lockdowns, holidays, and emergencies. The group process, organization, and methodology are not structured in a uniform manner. This monitor visited units and noticed that activity schedules were posted near and around the nursing station. Activities listed on the activity boards were limited to indoor board games and parties (for example, birthdays).

The table below showing the number of supplemental activities scheduled for the month (N), the number of activities conducted for the month (n), and the mean percentage of compliance (%C) is a summary of the facility's data:

	5/08	6/08	7/08	8/08	9/08	10/08	Mean
N	167	184	177	224	402	641	
n	166	183	176	177	335	513	
%C	99	99	99	79	83	80	86

As the table above shows, the number of activities offered has increased, especially in September and October 2008. The number of activities offered during this review period is much higher than during the previous review period. For example, there were 135 groups in October 2008 and 641 groups in October 2008.

The activity coordinator is structuring the process and procedures to establish a uniform methodology by which the groups are organized and conducted. PSH will encourage individuals to participate in their chosen

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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. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.</td></tr>
<tr><td>C.2.i.xii</td><td>is consistently reinforced by staff on the therapeutic milieu, including living units.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2008:
• All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.
• Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.

Findings:
Using item 12 from the DMH WRP Chart Auditing Form, PSH assessed its compliance based on observation on an average random sample of 11% of the WRPs due each month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>12.</td><td>Adequate active psychosocial rehabilitation is consistently reinforced by staff on the therapeutic milieu, including living units.</td><td>12%</td></tr>
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Comparative data showed slight improvement in compliance since the</td></tr>
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last review as follows:

	Previous period	Current period
Mean compliance rate		
12.	7%	12%
Compliance rate in last month of period		
12.	8%	17%

This monitor reviewed six charts (AM, EM, MD, MM, RJ and RLC). One of the WRPs in the charts (RJ) specified therapeutic milieu interventions in addition to active treatment interventions in the intervention sections of the WRPs. The remaining five (AM, EM, MD, MM and RLC) did not fulfill this criteria.

This monitor observed four Mall groups (Pathways Intake To Orientation Mall Group, Court Preparation Mall Group, Stress Management Technique Mall Group, and Fast Track PC 1370 Mall Group). The staff in these activities frequently and appropriately reinforced individuals in their groups.

As plan of correction, PSH plans to share the audit data with the Clinical Administrator, identify reasons for low compliance and take steps to correct them. PSH will get the mentors to assist WRPTs with overcoming barriers and refer low-performing teams to Psychiatry Seniors for supervisory oversight.

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.

C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1-4, June 2008:** • Establish group exercises and recreational activities for all individuals. • Provide training to Mall facilitators to conduct the activities appropriately. • Track and review participation of individuals in scheduled group exercise and recreational activities. • Implement corrective action if participation is low. **Findings:** Documentation review found that PSH offered 150 exercise groups, and 293 recreational groups. PSH tracks and monitors individuals' participation in the exercise groups but not the recreational activities. Documentation review also found that PSH had conducted seven training sessions during this review period. Fifty-three of the 102 exercise group facilitators had participated in the training. The table below showing the number of individuals in various BMI categories, the number of individuals participating in exercise groups, and the assignment rate is a summary of the facility's data: BMI Level | Individuals in each category | Individuals assigned to Exercise Groups | Percentage assigned 25 - 30 | 556 | 434 | 78% 31 - 35 | 300 | 219 | 73% 36 - 40 | 135 | 110 | 81% >40 | 50 | 41 | 82% As shown in the table above, the mean participation rate of individuals with high BMI is low, around 77%. PSH should enroll all individuals with

		high BMIs to at least one exercise groups, and encourage consistent participation in their assigned activities. As plan of correction, PSH will establish a tracking system to review individuals' participation in their scheduled groups. PSH plans the use the By Choice system and offer as reinforcement other non-food items to improve participation. **Compliance:** Partial. **Current recommendations**: 1. Establish group exercises 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.
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to provide family therapy services as needed. **Findings:** PSH has approved and/or updated ADs 11.05 (Notification of Patient Family Admission/Transfer) and 15.47 (Policy requirements and processes for family services), and the Family Therapy Audit Form. PSH has hired a Family Service Coordinator to handle all family therapy-related matters. PSH also trained its Social Work staff on the Family Services Program and has initiated contact with numerous agencies in the community to educate and offer family therapy services including

the Tri-County (San Bernardino, Riverside, Los Angeles) NAMI Chapter Presidents, Orange County Family to Family project leader, and PSH's Forensic Office and Social Work Services Secretary for FSP public relations intervention. PSH has arranged for family members to have direct access to the appropriate Social Work staff. PSH also invited family members to attend NAMI and Family Education activities, and held a "Family Day" event for Unit N-21. In September 2008, PSH conducted a workshop ("The Family Experience") during their Annual Forensic Conference. PSH had made a number of presentations during the monthly NAMI-Patton meetings (May: "Involuntary Medication"; June: "Communication Tips with Family Members"; July: "The Conditional Release Program", August: "Limit Setting and Boundaries with Family Members"; September: Community Integration Services at Patton"; October: "Implementation of Family Services at Patton").

Using item 1 from the DMH C2K Family Therapy Auditing Form, PSH assessed its compliance based on a 100% sample of individuals with an assessed need for family therapy for each month (May to October 2008). The table below is a summary of the data:

1.	*Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.*	78%
1.a	*General family education in the primary or preferred language of the family is provided to the family, either in person or by mail.*	92%
1.b	*There is documentation in the 30-day Psychosocial Assessment, the SW assessed the family's ability and willingness to be involved in the individual's recovery, and*	86%
1.c	*The Social Worker identified and documented potential barriers to the family's involvement in the*	88%

	individual's recovery.	

Using item 2 from the DMH C2K Family Therapy Auditing Form, PSH assessed its compliance based on a mean sample of 35% individuals with an assessed need for family therapy each month (May to October 2008). The table below is a summary of the data:

2.	*Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.*	0%
2.a	*There is documentation in the Present Status section of efforts to involve the family in the individual's WRPC and Recovery.*	34%
2.b	*In the individual's WRP, Focus 11 contains an objective that prepares the individual for his or her role within their family system, and*	8%
2.c	*There is documentation in the Present Status section that the identified barriers have decreased or there is evidence of continuing efforts to decrease the barriers.*	8%

According to the Chief of Social Work, the compliance shown in the table above is low due to lack of documentation in the Present Status section of the individuals' WRP. This requirement was introduced recently with the newly approved audit tool, and the staff was not informed about the change in a timely manner. However, the SW chief produced SW notes to show that collaboration among staff and the individual in preparation for family therapy and discharge has continued to take place.

<table>
<tr>
<td></td>
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<td>Using item 3 from the DMH C2K Family Therapy Auditing Form, PSH assessed its compliance based on a 100% sample of individuals with an assessed need for family therapy each month (May to October 2008). The table below is a summary of the data:
<table>
<tr><td>3.</td><td>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</td><td>100%</td></tr>
<tr><td>3.a</td><td>Family consultation and counseling was provided in preparation for discharge.</td><td>100%</td></tr>
<tr><td>3.b</td><td>The family was provided the individual's Social Work Recommended Continuing Care Plan, which includes aftercare plan, and</td><td>100%</td></tr>
<tr><td>3.c</td><td>Information was provided to the family on community resources.</td><td>100%</td></tr>
</table>
The Social Work staff at PSH has continued to improve its response to individuals' family therapy needs and discharge support.

Compliance:
Substantial.

Current recommendation:
Continue to provide family services as needed.</td>
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<tr>
<td>C.2.l</td>
<td>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</td>
<td>Current findings on previous recommendation:

Recommendation, June 2008:
See F.3.c.</td>
</tr>
</table>

	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:** PSH used the DMH Integration of Medical Conditions in WRP audit based on an average sample of 13% of individuals with at least one diagnosis listed on Axis III that have a WRP due each month (May–October 2008). The following table summarizes PSH's data:

1.	*All medical conditions listed on Axis III are included on the Medical Conditions Form.*	64%
2.	*The WRP includes each medical condition listed on the Medical Conditions Form 42.*	56%
2.a	*Each medical condition or diagnosis listed on the Medical Conditions form has a focus statement.*	60%
2.b	*Each medical condition or diagnosis listed on the Medical Conditions form has at least one objective.*	60%
2.c	*Each medical condition or diagnosis listed on the Medical Conditions form has at least one intervention.*	59%
3.	*There is an appropriate focus statement for each medical condition or diagnosis.*	5%
4.	*There is an appropriate objective for each medical condition or diagnosis.*	8%
4.a	*Each current medical condition or problem has at least one objective.*	48%
4.b	*The objective is written in observable, measurable and/or behavioral terms as to what the individual will do.*	8%
4.c	*The objective leads to improvement in the individual's quality of life.*	8%
5.	*There are appropriate interventions for each objective.*	1%
5.a	*Each objective related to current medical problem has at least one intervention.*	58%
5.b	*The intervention includes the related symptoms to*	9%

	be monitored by nursing staff for each condition.	
5.c	*The intervention specifies the means by which the staff will monitor these symptoms for each condition.*	6%
5.d	*The intervention specifies the frequency by which staff will monitor these symptoms for each condition.*	7%
5.e	*The intervention identifies staff to perform these interventions by title.*	20%

PSH's progress report indicated the following comparison data:

	Previous period	Current period
Mean compliance rate		
1.	48%	64%
2.	43%	56%
3.	7%	5%
4.	4%	8%
5.	1%	1%
Compliance rate in last month of period		
1.	58%	61%
2.	66%	50%
2.a	52%	52%
2.b	70%	58%
2.c	69%	57%
3.	4%	9%
4.	6%	8%
4.a	69%	50%
4.b	7%	8%
4.c	51%	8%
5.	2%	0%

	Previous period	Current period
Compliance rate in last month of period		
5.a	59%	59%
5.b	8%	8%
5.c	6%	5%
5.d	6%	5%
5.e	33%	17%

PSH's analysis indicated that Programs I and IV scored twice as high regarding compliance than Programs III and V. Items 3, 4, and 5 contributed to the lowest compliance scores. Regarding item 3 (focus statement), Program IV was the only program above 20% and unit 34 had 89% compliance while other units were at 40% or below. For item 4, Program IV had the highest compliance (27%) and units 35 and 73 had the highest compliance at 40% and 43% respectively. All programs scored below 30% regarding item 5, writing interventions. PSH's plan of correction indicated that the facility would identify strategies of the higher-scoring units and build on these methods in other units. In addition, PSH indicated that Program, Nursing, and Med/Surg management would review audit findings and develop a plan of correction.

A review of the WRPs of 43 individuals (AEG, AER, AJ, BGM, CH, CLR, CT, DAC, DMZ, DO, EA, EBW, EDL, GF, GH, GMM, HAB, JCS, JHB, JP, JSC, JWP, LLJ, LRO, MCB, MEM, MGD, MRO, MRR, NB, ND, OFL, PM, PWM, RDH, RJ, RPR, RSB, RWM, TEL, TOM, WPN and WRW) found that there has been little to no improvement in this area from the last review. The problematic areas continue to include inadequate and inappropriate nursing objectives and interventions. In addition, goals and objectives contained in the admission and integrated nursing assessments were frequently inconsistent with the information found in

the nursing admission and integrated assessments.

PSH also used the DMH Integration of Medical Conditions in WRP audit based on an average sample of 23% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review month (July-October 2008)

6.	*Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures.*	21%
6.a	*Refusals are documented in the Present Status section of the Case Formulation in the individual's WRP.*	28%
6.b	*When a pattern of refusal is evident or there is potential for adverse outcome, there are objectives and interventions dealing with the refusal in the individual's WRP.*	56%

No comparison data was provided in PSH's progress report. The facility indicated that this low compliance is a facility-wide issue not being addressed in the WRPs although the WRPTs acknowledge its clinical importance. PSH indicated that the plan of correction addressing this requirement included using mentors, seniors and trainings to increase awareness of refusals and review progress in two months.

A review of WRPs for 29 individuals who refused dental appointments (ABR, AG, AK, AM, BEM, DDA, DP, FEG, GLW, JAC, JL, JUH, KEO, KET, KG, KWY, LAG, LAL, MAK, MEM, RAB, ROS, RR, RS, RYB, TJ, TMP, VB and WC) found two in compliance.

Compliance:
Partial.

		Current recommendations: 1. Implement strategies to increase compliance with this requirement. 2. Increase sample size (20%) for audits regarding items 1-5. 3. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m and sub-cells are not applicable because PSH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Implement the policy and procedure regarding Substance Abuse Screening. **Findings:** In collaboration with MSH, PSH has developed and adopted a Substance Abuse Treatment Improvement Plan. The plan comports with generally accepted standards in guiding the screening and treatment processes. Implementation of the plan began on September 15, 2008. **Compliance:** Partial. **Current recommendation**: Provide summary information regarding specific actions taken as part of

		the implementation of the improvement plan.
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Provide an outline of the training provided to WRPTs and SAS providers related to this requirement during this reporting period. **Findings:** PSH has appointed Raafat Guirgis, MD, a psychiatrist with sub-specialty board certification in Addiction Psychiatry, as the new Substance Abuse Program Director. The facility also appointed ten full-time employees to form the Substance Abuse Assessment Team (SAAT). The range of disciplines included one RN, two social workers and seven psychiatric technicians. The team members are administratively supervised by the Program Director of the Enhancement Department. In October 2008, the facility provided 80 hours of training to SAAT members under the leadership of the Program Director. The training included lectures, audio-visual and written materials, discussion groups and role-playing sessions. Pre- and post-tests were administered to ensure competency in Substance Abuse assessment and treatment. The SAAT members are scheduled to conduct in-depth assessments of individuals with identified Axis I diagnosis of substance-related disorders who have been referred by the WRPTs. The following is an outline of the training: 1. Substance abuse overview (neurobiology, genetics and epidemiology) 2. Specific substances overview (including medical complications of abuse) a. Alcohol b. Sedative hypnotics c. Cocaine

		d. Methamphetamine e. Hallucinogens and club drugs f. Inhalants g. Nicotine and tobacco h. Opioids i. Anabolic steroids 3. Stages of Change 4. Addiction Severity Index (ASI) a. Theory, validity and reliability b. Using the screening instrument c. Scoring d. Practical sessions e. Discussion 5. Patient Placement Criteria (ASAM PPC, second edition) 6. Motivational Enhancement Therapy a. Theory b. MET practical principles c. ME interviewing d. ME treatment objectives and skills in different stages. 7. Matrix model of treatment 8. Cognitive behavioral treatment a. Functional analysis b. Cognitive restructuring c. Skill training d. Relapse prevention 9. Twelve-Step Facilitation (TSF) 10. Project MATCH 11. Contingency Management (theory and application) 12. Modified Therapeutic Community Model a. Enhancing social development b. Community integration c. Discharge planning 13. Group therapy (theory and process)

14. Supportive Psychodynamic Continuum
15. Drug testing
16. Co-occurring mental illness and substance abuse (Dual Diagnosis)
17. Addiction treatment in a forensic setting
18. Women and Addiction
19. HCV/HIV
20. Prescription drug abuse
21. Cultural aspects of addiction treatment
22. Spiritual aspects of recovery

Recommendations 2, 3 and 5, June 2008:

- Monitor this requirement using the DMH Substance Abuse Auditing Form based on at least a 20% sample.
- Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
- Ensure that all individuals receive substance abuse services based on their assessed needs.

Findings:

PSH used the DMH WRP Substance Abuse Auditing form to assess compliance (May to October 2008). The average sample was 14% of individuals with a current diagnosis of substance abuse as listed in the WRP, Integrated Assessment: Psychiatric Section or, if admitted before January 2008, the last monthly Psychiatric Progress Note. The following is a summary of the data:

1.	*Substance abuse is integrated into the case formulation and discussed in the present status.*	31%
2.	*There is an appropriate focus statement listed under Focus 5.*	42%
3.	*There is at least one objective related to the individual's stage of change.*	13%

4.	*There are interventions that are appropriately linked to the active objective(s).*	25%
5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.*	60%
6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.*	13%

Comparative data showed improved compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	14%	31%
2.	28%	42%
3.	4%	13%
4.	12%	25%
5.	48%	60%
6.	5%	13%
Compliance rate in last month of period		
1.	14%	37%
2.	37%	54%
3.	5%	17%
4.	18%	38%
5.	56%	60%
6.	6%	20%

Recommendation 4, June 2008:
Specify current status regarding development and implementation of clinical and process outcomes related to substance abuse services.

		Findings: PSH has finalized an appropriate set of process and clinical outcomes and plans to begin tracking these outcomes during the next review. The following is an outline: Process Outcomes: 1. Number of individuals screened for substance abuse per month; 2. Number of individuals with positive screens who have received substance abuse assessment as evidenced by chart audits; 3. Number of individuals with substance abuse who have Focus 5 (Substance Abuse) staged, with at least one objective and one intervention currently linked to their stage of change; 4. Number of SR providers trained in the SR curriculum and exhibiting an appropriate level of competency in this area; and 5. Number of SR groups currently being provided. Clinical outcomes: 1. Number of individuals making progress on the stages of change based on self-assessment using the Substance Abuse URICA scale; 2. Pre- and post-tests; 3. Processes of Change measures (as per the Substance Abuse Performance Improvement Plan); 4. Clinical outcome and reassessment measures as indicated by specific curricula; and 5. A Substance Abuse Track Worksheet that both individuals and their WRPTs can use to monitor progress through the SA treatment program. **Other findings:** This monitor reviewed the charts of six individuals who were diagnosed with a Substance Abuse Disorder (ELF, JME, JN, LHR, MC and MH).

		The review focused on the WRP documentation of the substance abuse diagnosis, focus/objectives/interventions related to the diagnosis, the individual's current stage of change and the linkage between the objectives/interventions and the stage of change. All WRPs included the diagnosis and five WRPs included focus/objective and interventions related to the diagnosis (ELF, JME, LHR, MC and MH). Only one chart (JME) included an appropriate stage of change that was properly linked to the objectives/interventions. **Compliance:** Partial. **Current recommendations**: 1. Provide an outline of the training provided to WRPTs and SAS providers during this reporting period. 2. Provide process and clinical outcome data and specify how clinical outcomes were determined if more than one mechanism was used to determine the outcome. 3. Monitor this requirement using the DMH Substance Abuse Auditing Form based on at least a 20% sample. 4. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.2.p	Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor the competency of group facilitators and therapists in providing rehabilitation services. • Ensure that providers have education, training and experience appropriate to the scope and complexity of services provided.

Findings:
Using items 1-4 from the WRP Mall Facilitator Audit form, PSH assessed its compliance based on a mean sample of 12 facilitators for each month (May to October 2008). The table below is a summary of the data:

1.	*Instructional skills*	0%
2.	*Course structure*	9%
3.	*Instructional techniques*	0%
4.	*Learning process*	47%

As the table above shows, the facilitators evidenced poor competency in the items audited. PSH should review its facilitator training methodology and its trainer competency, as well as review its audit system and PSH should establish auditor inter-rater reliability. This monitor has difficulty understanding how the compliance rates for instructional skills and techniques can be zero for all the audited facilitators, particularly given the training that has been provided to them over the last two-plus years.

PSH should also move from using audit data solely for documentation purposes to using the audit data to problem-solve. In speaking with the Mall facilitators, this monitor learned that feedback to individual facilitators on their performance is a rarity. PSH should consider having the auditors/senior mentors/trainers review the audit data with the facilitators. PSH should have its auditors note reasons for such low performance (see the reasons given by this monitor below).

In addition, PSH's sample for this audit was very small.

This monitor observed four Mall groups (Pathways Intake To Orientation Mall Group, Court Preparation Mall Group, Stress Management Technique Mall Group, and Fast Track PC 1370 Mall Group).

		Overall, all four groups were not well conducted. In most cases, the structure of the rooms led to difficulty for the providers to conduct meaningful facilitation; Mall groups adjacent to the nursing station had individuals and staff walk in and out, creating a distraction to both the facilitator and the individuals. The substitute facilitators in some groups did not have the knowledge to adequately manage the groups or answer the individuals' questions. Combined groups were large, making it difficult for the facilitator to provide meaningful facilitation. Two groups were held in the kitchen facility (one group can see and hear the other group) and individuals were moving back and forth between the groups, posing a disruption to both the facilitators and the individuals. This monitor learned from Mall facilitators that rotating co-facilitators does not work because the co-facilitators were not enduring, were not committed to the groups, and were not prepared when primary facilitator were absent. As plan of correction, PSH intends to increase the number of auditors, train the auditors, establish inter-rater reliability, and ensure that audits are conducted regularly on a monthly basis. **Compliance:** Noncompliance. **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.
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that all group facilitators complete the substance abuse training

		curriculum. **Findings:** According to the Mall Director, PSH has sufficient numbers of trained staff to facilitate substance abuse treatment groups. PSH also has provided 80 hours of didactic and practical training to 10 Substance Abuse Assessment Team (SAAT) members. The 10 SAAT members are certified to assess individuals with Axis 1 diagnosis of substance abuse related-disorders. PSH plans to train and certify an additional 50 substance abuse treatment group providers. **Recommendation 2, June 2008:** Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency. **Findings:** This monitor's interview of the Mall Director and training documentation review found that all providers serving individuals at the pre-contemplation stage have received training. **Compliance:** Substantial. **Current recommendations**: 1. Ensure that all group facilitators complete the substance abuse training curriculum. 2. Ensure that providers serving individuals at the pre-contemplation stage are trained to competency and meet substance abuse counseling competency.

C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Establish an automated system to track cancellation of scheduled appointments. **Findings:** PSH has yet to establish an automated system that allows tracking of cancellation of scheduled appointments. According to the Mall Director, the WaRMSS scheduler still is incomplete. As for now, only the Dental Department keeps track of cancellations of scheduled appointments. **Recommendation 2, June 2008:** Ensure that all appointments are completed. **Findings:** The table below showing the number of dental appointments scheduled, the number of dental appointments cancelled, and the reasons for the cancellations is a summary of the facility's data:

Missed Appointments Monitoring – Dental Services			
Month	Appointments		Reasons for Cancellation
	Scheduled	Cancelled	
May	373	27	27 staffing 0 transportation
June	395	23	23 staffing 0 transportation
July	325	30	30 staffing 0 transportation
Aug	317	29	29 staffing 0 transportation
Sept	365	14	13 staffing 1 transportation

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<tr><td>Oct</td><td>432</td><td>26</td><td>25 staffing
1 transportation</td></tr>
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As the table above shows, there were 2,207 scheduled Dental appointments between May and October 2008. Seven percent (149) of the scheduled appointments were cancelled. Staffing shortage was the primary reason for cancellation of these appointments. Only two appointments were cancelled due to transportation issues. PSH should audit all scheduled appointment and provide data showing the number of cancellations and the reasons for the cancellations.

This data conflicts with information provided by the Dental Department indicating that in August and September 2008, only one appointment was canceled due to staffing and none were canceled due to transportation issues. See F.9.d.

Compliance:
Partial.

Current recommendations:
1. Establish an automated system to track cancellation of scheduled appointments.
2. Ensure that all appointments are completed.
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<tr>
<td>C.2.s</td>
<td>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted</td>
<td>
Current findings on previous recommendations:

Recommendation 1, June 2008:
Ensure that individuals' cognitive levels, needs and strengths are utilized when considering group assignments.

Findings:
Using item 10 from the DMH Clinical Chart Auditing Form, PSH assessed its compliance based on a mean sample of 2% of the WRPs due each
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professional standards of care.

month (May to October 2008). The table below is a summary of the data:

10.	*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.*	63%
10.a	*The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.*	66%
10.b	*For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.*	88%
10.c	*All interventions are offered at the cognitive functioning level of the individual.*	88%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.	3%	63%
Compliance rate in last month of period		
10.	78%	64%
10.a	93%	64%

	Previous period	Current period
Compliance rate in last month of period		
10.b	84%	90%
10.c	84%	90%

As the above tables show, not all individuals are assigned to Mall groups based on their cognitive levels and assessed needs. This monitor's findings from documentation review (JGC, LTH, MLB and SMC), observation of WRPCs, observation of Mall groups, and interview of the Mall Director was in agreement with the facility's data. However, PSH has started to address this recommendation. WRPTs are using cognitive screening information from Integrated Assessments to determine the individual's cognitive levels. The next step for the WRPTs is to match the individual's cognitive level with a course that is developed for that level.

As plan of correction, PSH has designated a new master trainer, increased the number of master trainers, and will bring on a senior psychiatrist to assist with compliance with this recommendation.

Recommendation 2, June 2008:
Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to meet individuals' needs.

Findings:
PSH's monitoring data shows that the audited facilitators performed poorly across all variables audited. However, the data does not give any indication as to the reasons for the poor performance. This monitor's Mall group observation and Mall facilitator interview found that the regular facilitators of various groups had the knowledge and were motivated to serve the individuals as best as they could to meet the

individuals' needs. Nevertheless, this monitor's observation of Mall groups found that the groups were not well facilitated. It was clear that motivation was high with the substitute staff, but they were not trained and did not have the knowledge of the course content. It was difficult to determine facilitator knowledge and competency in other groups because groups were combined, the groups were too large, or the groups were held in unsuitable settings, causing interruption/ interference with meaningful facilitation. PSH should look into these matters before determining that more training is the answer.

Recommendation 3, June 2008:
Ensure that progress notes are written in a timely fashion and made available to the individual's WRPT.

Findings:
Using item 11.c from the DMH Clinical Chart Audit Form, PSH assessed its compliance based on a mean sample of 2% of the WRPs for each month (May to October 2008). The table below is a summary of the data:

11.c	*There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual's WRP.*	0%

Comparative data showed a decline in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
11.c	14%	0%

This monitor's review of eight charts (EP, LD, MM, RL, RW, TD, VF and

		WM) found that none of them contained all the required monthly progress notes for each active treatment provided to each individual. The progress notes found in the charts lacked information to be of much use to the WRPTs in making decisions regarding the individual's progress or lack thereof. **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.
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Implement and monitor PSH Mall Facilitator Monthly Progress Notes. • Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual. **Findings:** Using item 11 from the DMH Clinical Chart Audit Form, PSH assessed its compliance based on a mean sample of 2% of the WRPs each month (May to October 2008). The table below is a summary of the data: 11. *Treatment, rehabilitation and enrichment services are monitored appropriately against rational,* 2%

	operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.(C.2.t)	
11.a	*Each objective is observable, measurable and behavioral.*	10%
11.b	*All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual`s WRP.*	32%
11.c	*There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual`s WRP.*	0%
11.d	*If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.*	5%
11.e	*If the individual has met the objective, a new objective and related interventions have been developed and implemented.*	56%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
11.	0%	2%
Compliance rate in last month of period		
11.	9%	0%
11.a	37%	9%
11.b	44%	18%
11.c	14%	0%

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<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>11.d</td><td>19%</td><td>10%</td></tr>
<tr><td>11.e</td><td>13%</td><td>50%</td></tr>
<tr><td>11.f</td><td>9%</td><td>0%</td></tr>
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This monitor reviewed the charts of five individuals (CW, JGC, KAF, KED and SMG). The charts contained fewer than the required number of Monthly Mall Progress Notes. None of the WRPs in the charts had integrated information from the progress notes. In large part, this could be a function of the absence of useful information in the notes. Most notes merely check the boxes without any information about the individual's participation and progress.

Compliance:
Partial.

Current recommendations:
1. Implement and monitor PSH Mall Facilitator Monthly Progress Notes.
2. Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual.
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<tr>
<td>C.2.u</td>
<td>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</td>
<td>
Current findings on previous recommendations:

Recommendations 1-3, June 2008:
• Increase the number of groups that offer WRP education.
• Provide data regarding number of individuals attending WRP education during the course of hospitalization.
• Provide data analysis that delineates and evaluates areas of low
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compliance and relative improvement (during the reporting period and compared to the last period).

Findings:
PSH reported that 1,366 out of 1,509 individuals have attended WRP education. The facility has begun a process of providing WRP education based on individuals' needs. This process includes post-tests to determine if individuals have achieved the objectives of these groups and no longer require this intervention. A 40-item post test is being administered to individuals in each of the WRP groups. Newly admitted individuals will continue to be offered WRP education group until individuals have demonstrated proficiency. A database will be developed to track individuals' attendance at WRP education groups and to track individuals who have "tested out." PSH is considering implementation of the Sponsor Group process that was initiated at ASH.

The following is a summary of the data regarding WRP education groups offered during this review period:

Number of the Recovery Education groups (with hours) offered during the current and previous three Mall terms			
Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008	Oct-Nov 2008
44	67	44	39

Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (May to October 2008, mean)	
Sessions scheduled	793
Sessions held	747
% held	94%
# individuals scheduled	1478
# individuals attended at least one group per month	1467
% attended	99%

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Compliance:
Partial.

Recommendations:
1. Provide data regarding the process of post-testing and the number of individuals who have "tested out" of WRP education during the review period.
2. Provide data regarding the target population and the number of WRP education groups offered to these individuals. Include the number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.
3. Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment.

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<tr>
<td>C.2.v</td>
<td>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.</td>
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Current findings on previous recommendation:

Recommendation, June 2008:
Increase the number of groups that offer education regarding medication management.

Findings:
The number of these groups has increased slightly since the last review. The facility is currently in the process of developing post-tests to determine if individuals have achieved the objectives of these groups and no longer require this intervention. The following is a summary of the facility's data for this review period.

<table>
<tr><td colspan="4">Number of Medication Management groups (with hours) offered during the current and previous three Mall terms</td></tr>
<tr><td>Jan-Mar 2008</td><td>Apr-Jun 2008</td><td>Jul-Sep 2008</td><td>Oct –Dec 2008</td></tr>
<tr><td>38</td><td>67</td><td>64</td><td>69</td></tr>
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<table>
<tr><td colspan="2">Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (May to October 2008, mean)</td></tr>
<tr><td>Sessions scheduled</td><td>1514</td></tr>
<tr><td>Sessions held</td><td>1319</td></tr>
<tr><td>% held</td><td>87%</td></tr>
<tr><td># individuals scheduled</td><td>939</td></tr>
<tr><td># individuals attended at least one group per month</td><td>893</td></tr>
<tr><td>% attended</td><td>95%</td></tr>
</table>

Compliance:
Partial.

Current recommendations:
1. Provide data regarding the process of post-testing and the number of individuals who have “tested out” of medication education during the review period.
2. Provide data regarding the target population and the number of medication education groups offered to these individuals. Include number of groups per term, the hours offered and the number of individuals attending and compare to the last review period.
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<tr>
<td>C.2.w</td>
<td>Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual’s barriers to participation in therapeutic and rehabilitation services.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, June 2008:
• Assess barriers to individuals’ participation in their WRPs and provide strategies to facilitate participation.
• Use systematic methods of behavior change including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to change individuals’ attitudes toward participation in assigned groups and individual therapies.
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		Findings: PSH has not yet addressed these recommendations. **Recommendation 3, June 2008:** Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability. **Findings:** PSH has provided these data (see key indicators in the appendix). The facility acknowledged that patterns in the data may be unreliable due to the fact that individuals are sometimes counted as refusing Mall groups when groups are cancelled or when individuals are in medical or legal appointments. **Compliance:** Partial. **Current recommendations**: 1. Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation. 2. Use systematic methods of behavior change, including Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions, to change individuals' attitudes toward participation in assigned groups and individual therapies. 3. Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. In general, PSH has improved the quality of the psychiatric integrated assessments. 2. PSH filled half of the senior psychiatrist supervisory positions as of September 1, 2008. 3. PSH began hospital-wide implementation of the DMH revised templates for the Admission Medical and Psychiatric Assessment. **Summary of Progress on Psychological Assessments:** 1. PSH has staffed 93% of its required psychologist positions. Nearly 20% of the psychologists are bilingual. 2. PSH has implemented all DMH-approved manuals. 3. PSH has successfully reviewed and where necessary re-assessed integrated assessment of individuals admitted to PSH before the EP effective date (June 2006). 4. The quality of the Integrated Assessments: Psychology Section has improved. **Summary of Progress on Nursing Assessments:** 1. Ninety-five percent of RNs have received and passed the Admission and Integrated Assessment training. 2. PSH is implementing a number of strategies to increase the attendance of RNs and Psychiatric Technicians at the WRPCs. 3. PSH has implemented the Admission Suite project to increase the consistency of RNs who conduct admission assessments. **Summary of Progress on Rehabilitation Therapy Assessments:** 1. Assessments and audit tools for the IA-RTS and focused assessments for Speech Therapy, Physical Therapy, Occupational Therapy, Comprehensive Physical Rehabilitation Therapy assessment and Vocational Rehabilitation have been implemented.

		A D.4 monitoring tool has been developed and implemented that aligns with EP requirements. 2. Mentoring and training for psychosocial Rehabilitation Therapists on an individualized and group basis based on audit results has been initiated. 3. Data analysis based on requisite audit samples for each area of D.4 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Nutrition Assessments:** 1. Timeliness and completion of Nutrition type D.5.i and D.5.j.ii assessments continues to be affected by decreased staffing resulting in increased caseloads. 2. Data analysis based on requisite audit samples for each area of D.5 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Social History Assessments:** PSHs Integrated Assessments: Social Work section is complete and comprehensive. The education, social and inconsistency sections are completed in almost all of the assessments. **Summary of Progress on Court Assessments:** PSH has maintained substantial compliance with the requirements regarding PC 1026 and PC 1370 court reports. In order to maintain this

		level of compliance in the future, the facility needs to address the recommendations in this report.

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:** <u>Interviewed</u>: 1. George Christison, MD, Acting Chief of Psychiatry 2. Rebecca Kornbluh, MD, Chief of Professional Education 3. Steven Mauer, MD, Chief of Medical Staff <u>Reviewed</u>: 1. The charts of the following 51 individuals: AAC, AEJ, AER, AJ, AJW, AM, AM-2, ANM, ARB, AW, BB, BJB, BW, CC, CCN, CCS, DAR, EJM, ELF, GD, GWA, GWD, HRB, JAP, JC, JME, JN, JR, JS, KM, KS, LEF, LFV, LHR, LV, MAK, MG, MH, OV, PF, RHR, RM, SAB, SEF, SJM, TLM, TT,VAB, VLM, WAM, WDS and WJB 2. PSH database of all individuals with their diagnoses and medication regimens 3. DMH revised template for the Admission Medical Assessment 4. PSH Initial Medical Assessment Monitoring Form 5. PSH Initial Medical Assessment Monitoring summary data (May to October 2008) 6. DMH revised template for the Admission Psychiatric Assessment 7. DMH Admission Assessment Instructions 8. DMH Admission Psychiatric Assessment Auditing Form 9. PSH Admission Psychiatric Assessment summary data (May to October 2008) 10. DMH Integrated Psychiatric Assessment Auditing Form 11. PSH Integrated Psychiatric Assessment Auditing summary data (May to October 2008) 12. PSH Admission Medical Assessment Auditing Form 13. PSH Admission Medical Assessment Auditing summary data (May to October 2008) 14. DMH Weekly PPN Auditing Form 15. PSH Weekly PPN Auditing summary data (May to October 2008)

		16. PSH template for documentation of monthly psychiatric reassessments 17. DMH Monthly Physician Progress Note (PPN) Auditing Form 18. PSH Monthly PPN Auditing summary data (May to October 2008) 19. DMH Physician Transfer Note Auditing Form 20. PSH Physician Transfer Note Auditing summary data (May to October 2008)
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Standardize the monitoring tool regarding the Initial Medical Assessment. **Findings:** The DMH is in the process of finalizing this tool. **Recommendations 2- 4, June 2008:** • Implement the above-mentioned corrective action plan to improve compliance. • Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least 20%. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance (May to October 2008). The average samples were 54% of admission assessments, 30% of integrated assessments and 15% of monthly notes on individuals who have been hospitalized for more than

90 days. The following is a summary of the data and the facility's analysis, as applicable.

Admission Assessment		
4.a	*Admission diagnoses Axis I-V are addressed*	96%
4.b	*DSM-IV diagnosis consistent with history and presentation*	90%

Comparative data showed an overall mean compliance rate of 90% for item 4, compared to 65% for the last review.

Integrated Assessment		
2.b	*Statements from the individual are included, if available*	87%
2.d	*Includes diagnosis and medications given at previous facility are included*	74%
7.	*Includes diagnostic formulation*	94%
8.	*Includes differential diagnosis*	73%
9.	*Includes current psychiatric diagnoses*	89%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	88%	94%
8.	69%	73%
9.	99%	89%
Compliance rate in last month of period		
2.b	100%	89%
2.d	64%	95%

	Previous period	Current period
Compliance rate in last month of period		
8.	66%	74%
9.	100%	84%

The facility did not provide mean compliance for items 2.b and 2.d for the previous review period.

Monthly PPN		
3.b.1	*The note includes the five-axis diagnosis and this is consistent with the current presentation and recent developments*	88%
3.b.2	*If there is a NOS diagnosis or no diagnosis on Axis I, there is documentation that justifies the diagnosis*	50%
3.b.3	*Deferred and rule-out diagnosis are resolved within 60 days of initiation of the diagnosis and there is a clear description of the rationale for the specific resolution*	30%

Comparative data showed a mean compliance rate of 83% for the current period, compared to 72% during the last review. However, this rate appears to be too high given the compliance rates for sub-items 3.b.2 and 3.b.3. The facility did not provide point-to-point comparative data (last month of the previous period to last month of the current period) for item 3.b.

To improve compliance with the requirements in D.1, the facility has implemented the following corrective actions:

1. Half of Senior Psychiatrist Supervisor positions were permanently

		filled as of September 1, 2008 to provide needed supervision. 2. Three new psychiatrists were hired. 3. A facility-wide PPN template was improved after feedback from practitioners. 4. The Acting Chief of Psychiatry mandated that the monthly PPN template be completed and all notes be typed or dictated by all practitioners scoring below 85% on audits. 5. Effective October 2008, facility-wide results on audits have been presented at the Department of Psychiatry meeting. 6. Senior psychiatrists began to review documentation on high-risk individuals as part of the trigger review process. 7. The Acting Chief of Professional Education has prepared an individualized audit performance profile for each psychiatrist on the non-admission units. 8. The facility plans to develop admission unit audit performance profiles effective January 2009. 9. The results of the audit performance profile were reviewed with the individual psychiatrists, focusing in particular on those who scored in the lowest quartile. Feedback was provided. This process will be repeated quarterly for all unit psychiatrists. 10. The Acting Chief of Psychiatry plans to review Program audit results and provide feedback to Program Senior Psychiatrists. **Other findings:** The DMH has finalized a new template for the admission psychiatric assessment that includes suicide and violence risk. The new template meets current generally accepted professional standards of care and proper implementation can significantly enhance compliance with EP requirements. PSH recently began implementation of this template. Random chart reviews by this monitor found that this format was implemented in a few charts and that implementation has improved the quality of the assessments compared to the last review.

		However, this monitor found a persistent pattern of deficiencies in the overall quality of the admission and integrated assessments and reassessments (see examples in D.1.c.ii, D.1.c.iii and D.1.f). These deficiencies must be corrected to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations**: 1. Ensure full implementation of the DMH revised template for the Admission Psychiatric Assessment. 2. Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure consistent compliance with this requirement. **Findings:** At this time, PSH has one staff psychiatrist who has clinical responsibilities and who has not completed psychiatry training as required. This practitioner is board-certified in family medicine.

		Compliance: Partial. **Current recommendation**: Ensure consistent compliance with this requirement.
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Implement the Physician Performance Profile and utilize data in the process of reappointment/reprivileging. **Findings:** Since the last review, PSH has completed a physician (psychiatrist) performance profile that includes results from all audits pertaining to the role of the team leader. This profile was developed for all non-admission unit psychiatrists and has been used by Senior Psychiatrists to monitor and measure quality of care by unit psychiatrists. The facility plans to continue this process for all staff psychiatrists. PSH has yet to utilize information from the physician performance profile in the process of reprivileging. The facility reported that a peer review system is currently used in the process of reprivileging but did not explain how this system interfaces with the information gathered in the performance profile. **Compliance:** Partial. **Current recommendation**: Utilize data from the physician performance profile in the process of reappointment/reprivileging of physicians.

D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the standardized DMH tool based on at least a 20% sample and ensure that monitoring addresses the quality of the assessments, including the plan of care and follow-up regarding incomplete examinations. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** The DMH has yet to standardize this tool. Using the PSH Initial Admission Medical Assessment Monitoring Form, the facility assessed its compliance (May to October 2008). The average sample was 99% of admissions per month. The compliance rates are presented in each corresponding cell below. **Other findings:** This monitor reviewed the charts of 10 individuals (AAC, DAR, EJM, ELF, JME, JN, LHR, MAK, MG and MH) who were admitted during this reporting period. The review found the following: 1. The admission medical assessments were completed in a timely manner in all charts except one (MH). 2. Some charts (AAC, EJM and LHR) included medical assessments that were completed using the DMH newly revised template. This template included appropriate prompts to correct the deficiencies outlined in the previous reports. 3. The medical assessments that were completed using the facility's old format included incomplete plans of care in most cases. For

		example, the chart of AAC did not include a plan of care for the identified problem of psoriasis. 4. Some charts (AAC, EJM, JME and LHR) included reference to the individual's refusal of genital examination without documentation of follow-up regarding this matter. **Compliance:** Partial. **Current recommendations**: 1. Finalize and implement the DMH Initial Medical Examination Auditing Form and Instructions for use across facilities. 2. Ensure consistent implementation of the DMH's newly revised template for the admission medical assessment. 3. Monitor completeness of the admission medical examination within the specified time frame, based on at least a 20% sample. This monitoring must address follow-up regarding incomplete items on the examination. 4. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
D.1.c.i.1	a review of systems;	90%, compared to 89% during the last review.
D.1.c.i.2	medical history;	90% (same as the last review).
D.1.c.i.3	physical examination;	89% (same as the last review). The rate for the last month of this review period was 87% compared to 84% during the last month of the previous review period.
D.1.c.i.4	diagnostic impressions; and	90% (same as the last review).
D.1.c.i.5	management of acute medical conditions	90% (same as the last review).

D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement the new DMH template for the admission psychiatric assessment. **Findings:** The new template was introduced in August 2008 and has been regularly used since October 1, 2008. This template includes a risk assessment tool that aligns with the risk factors in the integrated psychiatric assessment. If properly implemented, the template provides corrections of the deficiencies that were reported in the previous report. **Recommendations 2 and 3, June 2008:** • Monitor this requirement using the standardized DMH tool based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Admission Psychiatric Assessment Auditing Form to assess compliance (May to October 2008). The average sample was 54% of the admissions each month. The mean compliance rate for this requirement was 85% compared to 84% during the last review. The rate for the last month of this review period was 100% compared to 74% during the last month of the previous review period. The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c .ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.

		Other findings: This monitor reviewed the charts of the above-mentioned 10 individuals. The review found substantial compliance in three charts (AAC, EJM and LHR) in which the DMH revised template for the admission psychiatric assessment was implemented. However, most of the charts reviewed included assessments that were completed using the older template. In general, the charts contained evidence of deficiencies similar to those cited in the previous report. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following are examples of the deficiencies: 1. The history of present illness did not include necessary information (MH). 2. The violence risk assessment did not include specific information in individuals who had significant history of aggression (KM and SGV). 3. The mental status examination included reference to the presence of auditory hallucinations without providing necessary specifics (DAR and MAK). In one chart (ELF), the assessment provided unintelligible elaboration regarding a reference to auditory hallucinations. 4. In the chart of JN, the admission diagnosis of "Mood Disorder Not Otherwise Specified" was in conflict with the mental status findings of "persecutory and grandiose delusions." **Compliance:** Partial. **Current recommendations**: 1. Ensure full implementation of the DMH revised template for the admission psychiatric assessment. 2. Monitor the Admission Psychiatric Assessment based on at least a 20% sample using the DMH standardized instrument. 3. Provide data analysis that evaluates and delineates areas of low

		compliance and relative improvement (during the reporting period and compared with the last period).
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	

2.	*Psychiatric history, including a review of presenting symptoms.*	73%
2.a	*Identifying data including legal status*	98%
2.b	*Discharge diagnosis and condition*	79%
2.c	*Reason for admission and chief complaint*	98%
2.d	*History of present illness*	96%
2.e	*Psychiatric history*	95%
2.f	*Substance abuse history*	97%
2.g	*Allergies*	98%
2.h	*Current medications*	94%

Comparative data showed mixed changes in compliance for since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	75%	73%
Compliance rate in last month of period		
2.	54%	75%
2.a	90%	99%
2.b	65%	92%
2.c	79%	97%
2.d	75%	100%
2.e	72%	95%
2.f	81%	99%
2.g	98%	95%
2.h	95%	90%

D.1.c.ii.2	complete mental status examination;	96%, compared to 90% during the last review.
D.1.c.ii.3	admission diagnoses;	90%, compared to 65% during the last review.
D.1.c.ii.4	completed AIMS;	99% (same as the last review).
D.1.c.ii.5	laboratory tests ordered; and	98%, compared to 99% during the last review.
D.1.c.ii.6	consultations ordered.	88%, compared to 57% during the last review. The rate for the last month of this review period was 85% compared to 100% during the last month of the previous review period.
	plan of care	

8	*Plan of care*	85%
8.a	*Regular psychotropic medications with rationale*	88%
8.b	*PRN and/or Stat medications as applicable, with specific behavioral indicators*	68%
8.c	*Special precautions to address risk factors as indicated*	85%

Comparative data showed some improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	83%	85%
Compliance rate in last month of period		
8.	67%	95%
8.a	67%	95%
8.b	N/A	100%
8.c	100%	100%

D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the standardized DMH tool based on at least a 20% sample. • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Integrated Assessment Psychiatry Section Auditing Form to assess compliance (May to October 2008). The average sample was 30% of the assessments. The mean compliance rate for this requirement was 90% compared to 92% for the previous review period. The mean compliance rates for the other requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate. **Other findings:** Reviews by this monitor found that the majority of the Integrated Psychiatric Assessments were completed within a reasonable timeframe that permitted integration of information that becomes available following admission. This monitor reviewed the charts of the above-mentioned 10 individuals. Overall, the facility appeared to have improved the quality of the assessments compared to the last review period. Examples of improved documentation were found in the charts of EJM, JME and MG. However, some deficiencies were found that must be corrected to achieve substantial compliance with this requirement. The following is a summary of the findings:

		1. The integrated assessments were not completed in the charts of AAC, JN and MAK. 2. The integrated assessment of DAR indicated that the individual was a high risk for suicide, but the assessment did not include any information regarding current suicidality. 3. The integrated assessment of MH included description of the individual as being depressed and having flat affect with poverty of speech. However, there was no documentation of an assessment of current suicidality. 4. The differential diagnosis in the assessment of an individual diagnosed with Psychotic Disorder, Not Otherwise Specified was inadequate (ELF). 5. The mental status examination included generic assessment of insight and judgment in several charts. 6. In almost all the charts, the assessment of strengths was limited to a generic list of the individuals' characteristics that could not be utilized in wellness and recovery planning. **Compliance:** Partial. **Current recommendations**: 1. Ensure full implementation of the integrated psychiatric assessments. 2. Provide training to WRPTs regarding the proper formulation of individuals' strengths. The training should focus on attributes of the individuals that could be utilized in wellness and recovery planning. 3. Continue to monitor the Integrated Psychiatric Assessment using the DMH standardized instrument. 4. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period

		and compared with the last period).
D.1.c.iii.1	psychiatric history, including a review of present and past history;	

2.	*Psychiatric history, including a review of present and past history*	62%
2.a	*Identifying data including legal status*	100%
2.b	*Statements from the individual are included, if available*	87%
2.c	*Chief complaint*	84%
2.d	*Diagnosis and medications given at previous facility are included*	74%
2.e	*Effectiveness of medications from previous facility is included*	62%
2.f	*Past psychiatric history is documented including a review of pertinent physical exam status*	94%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	50%	62%
Compliance rate in last month of period		
2.	57%	79%
2.a	100%	100%
2.b	100%	89%
2.c	99%	89%
2.d	64%	95%
2.e	61%	86%
2.f	97%	100%

D.1.c.iii.	psychosocial history;	

2		3.	*Psychosocial history is documented.*	68%
		3.a	*Developmental history*	78%
		3.b	*Family history*	94%
		3.c	*Educational history*	85%
		3.d	*Religious and cultural influences*	80%
		3.e	*Occupational history*	86%
		3.f	*Marital status*	83%
		3.g	*Sexual history*	78%
		3.h	*Legal history*	82%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	69%	68%
Compliance rate in last month of period		
3.	68%	58%
3.a	76%	78%
3.b	91%	94%
3.c	80%	100%
3.d	79%	83%
3.e	81%	100%
3.f	77%	89%
3.g	77%	78%
3.h	80%	84%

D.1.c.iii.3	mental status examination;	4.	*Complete mental status examination is documented*	70%
		4.a	*Attitude/cooperation*	100%
		4.ba	*General appearance*	99%

4.c	*Motor activity*	99%
4.d	*Speech*	100%
4.e	*Mood/affect*	10%0
4.f	*Thought process/content*	100%
4.g	*Perceptual alterations*	100%
4.h	*Fund of general knowledge*	87%
4.i	*Abstraction ability*	85%
4.j	*Judgment*	86%
4.k	*Insight*	86%
4.l	*MMSE*	75%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
4.	64%	70%
Compliance rate in last month of period		
4.	63%	68%
4.a	100%	100%
4.b	100%	100%
4.c	100%	100%
4.d	100%	100%
4.e	100%	100%
4.f	100%	100%
4.g	100%	100%
4.h	71%	89%
4.i	69%	88%
4.j	72%	89%
4.k	78%	94%
4.l	81%	83%

D.1.c.iii.4	strengths;	79%, compared to 83% in the last review. The rate for the last month of this review period was 89% compared to 84% during the last month of the previous review period.
D.1.c.iii.5	psychiatric risk factors;	

6.	*Psychiatric risk factors are documented*	27%
6.a	*Risk for suicide*	83%
6.b	*Risk for self-injurious behavior*	30%
6.c	*Risk factors for seclusion (medical and emotional)*	93%
6.d	*Risk factors for restraint (medical and emotional)*	92%
6.e	*Risk for aggression*	85%
6.f	*Risk for fire setting*	84%
6.g	*Risk for elopement*	83%
6.h	*Risk for victimization*	77%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.	22%	27%
Compliance rate in last month of period		
6.	46%	42%
6.a	86%	89%
6.b	51%	42%
6.c	59%	89%
6.d	59%	89%
6.e	83%	89%
6.f	82%	89%
6.g	82%	84%
6.h	82%	84%

<table>
<tr><td>D.1.c.iii.6</td><td>diagnostic formulation;</td><td>94%, compared to 88% during the last review.</td></tr>
<tr><td>D.1.c.iii.7</td><td>differential diagnosis;</td><td>73%, compared to 69% during the last review. The rate for the last month of this review period was 74% compared to 66% during the last month of the previous review period.</td></tr>
<tr><td>D.1.c.iii.8</td><td>current psychiatric diagnoses;</td><td>89%, compared to 99% during the last review.</td></tr>
<tr><td>D.1.c.iii.9</td><td>psychopharmacology treatment plan; and</td><td>
<table>
<tr><td>10.</td><td>Psychopharmacology treatment plan is documented</td><td>45%</td></tr>
<tr><td>10.a</td><td>Current target symptoms</td><td>63%</td></tr>
<tr><td>10.b</td><td>Specific medications to be used</td><td>97%</td></tr>
<tr><td>10.c</td><td>Dosage titration schedules, if indicated</td><td>86%</td></tr>
<tr><td>10.d</td><td>Adverse reactions to monitor for</td><td>56%</td></tr>
<tr><td>10.e</td><td>Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics in at-risk population, if indicated.</td><td>81%</td></tr>
<tr><td>10.f</td><td>Response to medications since admission, if applicable including PRN and Stat medications.</td><td>61%</td></tr>
<tr><td>10.g</td><td>Medication consent issues were addressed.</td><td>95%</td></tr>
</table>

Comparative data showed mixed changes in compliance with most sub-items since the last report as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>10.</td><td>53%</td><td>45%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>10.</td><td>62%</td><td>58%</td></tr>
<tr><td>10.a</td><td>72%</td><td>67%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>10.b</td><td>100%</td><td>100%</td></tr>
<tr><td>10.c</td><td>94%</td><td>88%</td></tr>
<tr><td>10.d</td><td>72%</td><td>59%</td></tr>
<tr><td>10.e</td><td>55%</td><td>100%</td></tr>
<tr><td>10.f</td><td>100%</td><td>100%</td></tr>
<tr><td>10.g</td><td>99%</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>D.1.c.iii.10</td><td>management of identified risks.</td><td>90%, compared to 85% during the last review.</td></tr>
<tr><td>D.1.d</td><td>Each State hospital shall ensure that:</td><td>Please see sub-cells for compliance findings.</td></tr>
<tr><td>D.1.d.i</td><td>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;</td><td>Current findings on previous recommendations:

Recommendation 1, June 2008:
Continue medical education programs to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders and provide data regarding number and disciplines of attendees.

Findings:
During this review period, PSH provided/facilitated a series of CME programs that were relevant to the care of individuals at the facility. However, none of these programs focused on the assessment/ management of cognitive and other neuropsychiatric disorders.

Recommendation 2, June 2008:
Same as in D.1.a.</td></tr>
</table>

Findings:
Same as in D.1.a.

Other findings:
This monitor reviewed the charts of 15 individuals who received diagnoses listed as NOS for three or more months during this review period:

Initials	Diagnosis
AEJ	R/O Dementia, NOS
AJW	Cognitive Disorder, NOS
BJB	Depressive Disorder, NOS
CC	Psychotic Disorder, NOS
GWD	Impulse Control Disorder, NOS
JC	Psychotic Disorder, NOS
JR	Dementia, NOS
KS	Depressive Disorder, NOS
LEF	Mood Disorder, NOS
LV	Mood Disorder, NOS
PF	Psychotic Disorder, NOS
SJM	Dementia, NOS
TLM	Cognitive Disorder, NOS
VAB	Mood Disorder, NOS
WJB	Cognitive Disorder, NOS

The review found persistent deficiencies in one or more of the following areas:

1. Finalization of the diagnosis, as indicated;
2. Assessment and tracking of the cognitive impairments, as indicated;
3. Alignment of the diagnostic information in the current WRP with the corresponding psychiatric progress notes, and/or

		4. Ensuring appropriate match between diagnosis and prescribed treatment. These deficiencies must be corrected to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations**: 1. Provide medical education programs to psychiatry staff to improve competency in the area of assessment of cognitive and other neuropsychiatric disorders and provide data regarding number and disciplines of attendees. 2. Same as in D.1.a.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in D.1.d.i. **Findings:** Same as in D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.d.i.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely	**Current findings on previous recommendation:**

	addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and	**Recommendation, June 2008:** 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.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in D.1.d.i. **Findings:** Same as in D.1.d.i. **Other findings:** During this review period, three individuals received this diagnosis on Axis I. Of these individuals, two were discharged from the facility, but the facility's report did not indicate if this diagnosis was reviewed to ensure justification. The third individual had this diagnosis as part of a psychological assessment that was completed at a previous facility. At the time of the tour, no individual at the facility carried "no diagnosis" on Axis I (as per the facility's report). **Compliance:** Substantial.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Same as in D.1.d.i.
2. Review the charts of all individuals who have received “No Diagnosis” on Axis I to determine clinical justification.</td></tr>
<tr><td>D.1.e</td><td>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.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2008:
• Monitor this requirement based on a review of at least a 20% sample.
• Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
PSH used the DMH Weekly Physician Progress Note (PPN) Auditing Form to assess compliance (May to October 2008). The average sample was 13% of the individuals with length of stay less than 60 days. The following is a summary of the data:

<table>
<tr><td>1.</td><td>The reassessments are completed weekly for the first 60 days on the admission units:</td><td>39%</td></tr>
<tr><td>1.a</td><td>There is a note present every seven days from the date of admission, with the understanding that the Integrated Assessment: Psychiatry Section can serve as the first weekly note.</td><td>45%</td></tr>
<tr><td>1.b</td><td>The note must contain the subjective complaint, objective findings, assessment and plan of care</td><td>88%</td></tr>
</table>

Comparative data showed a decrease in compliance for the mean rate, but improvement in the rates for the last months of the review periods. The following is a summary:</td></tr>
</table>

	Previous period	Current period
Mean compliance rate		
1.	44%	39%
Compliance rate in last month of period		
1.	44%	60%
1.a	44%	62%
1.b.1	64%	87%
1.b.2	73%	87%
1.b.3	73%	90%
1.b.4	73%	90%

The facility reported that compliance with the weekly progress notes has improved during this review period after the admission units became fully staffed.

Other findings:
This monitor reviewed the charts of 11 individuals (AAC, DAR, EJM, ELF, JME, JN, LHR, MAK, MG, MH and RR) who were admitted during this reporting period. The review focused on the timeliness of the notes. Regarding the weekly notes, there was compliance in six charts (AAC, EJM, JME, JN, MAK and MG) and partial compliance in five (DAR, ELF, LHR, MH and RR). The monthly notes were timely in all charts of individuals who were hospitalized for 90 or more days except one (RR).

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement based on a review of at least a 20% sample.
2. Provide data analysis that evaluates low compliance and delineates

		areas of relative improvement (during the reporting period and compared to the last period).
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Finalize and implement a format for psychiatric reassessments that ensures correction of the deficiencies outlined in this monitor's report and in the previous report. **Findings:** PSH has developed an adequate template for the documentation of psychiatric reassessments. However, the content of documentation showed deficiencies that must be corrected to achieve substantial compliance (see Other findings). **Recommendations 2 and 3, June 2008:** • Monitor this requirement based on a review of at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period). **Findings:** PSH used the DMH Monthly PPN Auditing Form to assess compliance (May to October 2008). The average sample was 15% of individuals who have been hospitalized for 90 or more days. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below. Comparative data are listed, as appropriate. The facility's plan of correction was the same as in D.1.a. **Other findings:** This monitor reviewed the charts of 19 individuals (AJ, AM, AM-2,

		ARB, AW, BB, CCN, GD, GWA, JC, JS, KM, LFV, OV, PF, RM, SEF, WAM and WJB) to assess the quality of documentation in the monthly notes. The reviews found general inconsistency in the implementation of the facility's template for the monthly notes and minor improvement in the content in these notes compared to the last review. Examples of improved documentation were found in the charts of AM, AM-2, ARB, GWA, KM, OV, RM, SEF and WAM. Inadequate documentation was noted in the charts of AJ, AW, BB, CCN, GD, JC, JS, LFV, PF and WJB. In general, this monitor found much lower compliance than that reported in the facility's data. The following are examples of the main areas of deficiency: 1. The documentation of interval events ignored some important developments during the interval. 2. The documentation of current status, relevant laboratory findings and risk factors did not include significant relevant changes in laboratory findings and associated risks for the individual nor adequately address these changes. 3. The documentation of risks and benefits of drug treatments was mostly a generic rehash of the theoretical side effects of medications while ignoring some actual and significant occurrences of side effects in some individuals. 4. The documentation of behavioral interventions was typically generic and reflected incomplete understanding of behavioral guidelines and PBS plans that were provided to some individuals. This monitor also reviewed the charts of six individuals who experienced the use of seclusion and/or restraints during this review period (ANM, CCS, HRB, LEF, SAB and VLM). The purpose of this review was to assess the use of PRN/Stat medications prior to seclusion and/or restraints (as documented in the orders and progress notes). This review was also relevant to the requirements in D.1.f.vi and F.1.b. The review found that PSH has made progress in providing

		appropriate behavioral interventions for some individuals who were refractory to current medication trials. However, the following pattern of deficiencies still existed: 1. PRN medications were prescribed for generic indications such as "agitation" (ANM, CCS, SAB and VLM). 2. PRNs were not ordered and/or administered in order to avert the use of seclusion and/or restraints as appropriate (HRB). 3. PRNs were ordered for symptoms that were inconsistent with the WRP diagnosis, with no subsequent attempts to revise the diagnosis as appropriate (LEF). 4. The PRNs that were administered were not properly matched to the stated reason for their administration (LEF). 5. The nursing documentation of the circumstances that led to the use of PRN/Stat medications and of the individual's response to these interventions was generally inadequate. For example, the reasons given for the administration of ziprasidone PRN (LEF), haloperidol and lorazepam (ANM) and olanzapine PRN (CCS) were listed as "anxiety," "agitated" and "Assaultive Behavior," respectively, without any specifics. There was no documentation on the MTR of the result of administration of PRN olanzapine for CCF. 6. There was inadequate documentation in the physician progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustments of regular treatment following the use of PRN medications. 7. The documentation of a face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications was either missing or did not include a critical review and assessment to inform future management (LEF and VLM). **Compliance:** Partial.

		Current recommendations: 1. Streamline the format of psychiatric reassessments and ensure consistent implementation to correct the deficiencies outlined in this monitor's report and in the previous report. 2. Monitor this requirement based on a review of at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow-up;	

2.a	*Subjective complaints are documented*	93%
2.b	*Identified target symptoms are documented*	87%
2.c	*Participation in treatment is documented*	87%
2.d	*Progress towards objectives in the WRP*	81%
2.e	*The mental status exam is documented*	95%
2.f	*The individual's legal status and any change in legal status, if applicable*	86%
2.g	*Current status of medical problems and treatment are documented*	83%
2.h	*Relevant lab data and consults are documented*	70%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	25%	67%
Compliance rate in last month of period		
2.	40%	66%
2.a	89%	85%

	Previous period	Current period
Compliance rate in last month of period		
2.b	75%	94%
2.c	74%	90%
2.d	61%	82%
2.e	95%	91%
2.f	76%	85%
2.g	44%	80%
2.h	45%	70%

D.1.f.ii Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;

3.a	*The MMSE is completed and documented in the progress note.*	71%
3.b	*The current diagnosis includes resolution of NOS, deferred, and rule out diagnoses, if applicable.*	83%

Comparative data showed improvement since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	39%	64%
Compliance rate in last month of period		
3.	46%	58%
3.a	60%	65%
3.b	72%	83%

<table>
<tr>
<td>D.1.f.iii</td>
<td>Analyses of risks and benefits of chosen treatment interventions;</td>
<td>
<table>
<tr><td>4.a</td><td>The risks for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>74%</td></tr>
<tr><td>4.b</td><td>The benefits for the current psychopharmacology plan including anticholinergics, benzodiazepines, and %polypharmacy are documented.</td><td>77%</td></tr>
<tr><td>4.c</td><td>Rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented</td><td>74%</td></tr>
</table>

Comparative data showed improvement since the last review as follows:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>4.</td><td>34%</td><td>67%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>4.</td><td>53%</td><td>63%</td></tr>
<tr><td>4.a</td><td>54%</td><td>77%</td></tr>
<tr><td>4.b</td><td>63%</td><td>79%</td></tr>
<tr><td>4.c</td><td>63%</td><td>70%</td></tr>
</table>
</td>
</tr>
<tr>
<td>D.1.f.iv</td>
<td>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;</td>
<td>
<table>
<tr><td>5.a</td><td>There is a description of the current risks specific to this individual and the precautions instituted to minimize those risk.</td><td>67%</td></tr>
<tr><td>5.b</td><td>The monthly note identifies specific risk behaviors including triggers during the interval period.</td><td>70%</td></tr>
<tr><td>5.c</td><td>If applicable, treatment is modified to minimize risk.</td><td>66%</td></tr>
</table>
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<table>
<tr>
<td></td>
<td></td>
<td>Comparative data showed improvement in compliance since the last review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>5.</td><td>32%</td><td>60%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>5.</td><td>53%</td><td>57%</td></tr>
<tr><td>5.a</td><td>52%</td><td>67%</td></tr>
<tr><td>5.b</td><td>72%</td><td>71%</td></tr>
<tr><td>5.c</td><td>71%</td><td>69%</td></tr>
</table>
</td>
</tr>
<tr>
<td>D.1.f.v</td>
<td>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;</td>
<td>
<table>
<tr><td>6.a</td><td>Rationale for current psychopharmacology plan including analysis of risks and benefits.</td><td>76%</td></tr>
<tr><td>6.b</td><td>There is a description of any side effects caused by medications, including sedation and cognitive impairment.</td><td>78%</td></tr>
<tr><td>6.c</td><td>The AIMS was done annually for all individuals and quarterly if there is a positive AIMS or a current diagnosis or history of Tardive Dyskinesia.</td><td>84%</td></tr>
<tr><td>6.d</td><td>Response to pharmacologic treatment is documented. There is a description of the response to the psychopharmacologic regimen in terms of symptom reduction or other measurable objectives</td><td>83%</td></tr>
</table>
Comparative data showed improvement in compliance since the last review as follows:
</td>
</tr>
</table>

		Previous period	Current period
		Mean compliance rate	
		6.	34%	62%
		Compliance rate in last month of period	
		6.	56%	60%
		6.a	53%	72%
		6.b	73%	83%
		6.c	93%	81%
		6.d	73%	86%

D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use; and	7.a	*Describes the rationale/specific indications for all PRN orders.*	61%
		7.b	*Reviews the PRNs and Stats during the interval period.*	62%
		7.c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.*	42%
		7.d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.*	36%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	25%	48%

		Previous period	Current period
		Compliance rate in last month of period	
		7.	25%	42%
		7.a	47%	51%
		7.b	65%	45%
		7.c	33%	26%
		7.d	20%	15%

D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	8.a	*There is a description in the note of the response to non-pharmacologic treatment.*	76%
		8.b	*If applicable, there is documentation to support that the psychiatrist reviewed the PBS plan prior to implementation to ensure consistency with psychiatric formulation.*	59%
		8.c	*There is documentation to support evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacologic treatments, and document evidence of integration of treatments.*	53%
		8.d	*There is modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments.*	67%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	38%	59%
Compliance rate in last month of period		
8.	46%	57%
8.a	60%	73%
8.b	37%	44%
8.c	36%	56%

D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement a tracking system to facilitate monitoring of inter-unit transfers of individuals who present severe management problems to ensure adequate design and implementation of behavioral guidelines/PBS plans prior to transfer. **Findings:** The facility has instituted a system of review of the individuals' transfers by Psychological Specialized Services Committee (PSSC) prior to the transfer. If an emergency transfer occurs, individuals are reviewed by PSSC following the transfer. The facility's report implied that this system was not used consistently and did not specify that the review by the PSSC addressed the intent of this recommendation. **Recommendations 2 and 3, June 2008:** • Monitor this requirement based on a review of at least a 20% sample. • Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

Findings:
PSH used the DMH Physician Inter-Unit Transfer Note Auditing Form to assess compliance (May to October 2008). The average sample was 12% of all individuals transferred between WRPTs. The following is a summary of the data:

1.	*Psychiatric course of hospitalization*	21%
2.	*Medical course of hospitalization*	27%
3.	*Current target symptoms*	56%
4.	*Psychiatric risk assessment*	21%
5.	*Current barriers to discharge*	44%
6.	*Anticipated benefits of transfer*	29%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	38%	21%
2.	38%	27%
3.	47%	56%
4.	20%	21%
5.	20%	44%
6.	13%	29%
Compliance rate in last month of period		
1.	20%	18%
2.	40%	25%
3.	40%	50%
4.	40%	17%
5.	20%	73%
6.	20%	17%

Other findings:
This monitor reviewed the charts of six individuals who experienced inter-unit transfers during this reporting period:

Initials	Date of transfer
AER	09/02/08
BW	05/08/08
JAP	07/22/08
RHR	09/19/08
TT	06/04/08
WDS	10/30/08

The review found noncompliance in one chart (WDS) and partial compliance in five charts (AER, BW, JAP, RHR, and TT). The main deficiencies were as follows:

1. One transfer assessment was limited to a statement to continue current orders and a listing of medical conditions (WDS).
2. The anticipated benefits of the transfer were either not mentioned or stated in generic terms in all cases.
3. The course of hospitalization (psychiatric and medical), psychiatric risk assessment and discharge barriers were generally incomplete and inadequate to ensure continuity of care at the receiving unit.

These deficiencies must be corrected to achieve substantial compliance with this requirement.

Compliance:
Partial.

		Current recommendations: 1. Implement a tracking system to ensure adequate design and implementation of behavioral guidelines/PBS plans prior to transfers of individuals who present severe management problems. Provide specific information regarding implementation of this system. 2. Monitor this requirement based on a review of at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).

2. Psychological Assessments		
		Methodology: Interviewed: 1. Allison Pate, PhD, Senior Supervising Psychologist 2. David Haimson, PhD, Chief of Psychology 3. Dominique Kinney, PhD, Psychologist 4. Georgiana Vinson, RN 5. Helga Thordarson, PhD, Senior Supervising Psychologist 6. Steven Berman, PhD, Psychologist, By Choice Coordinator Reviewed: 1. The charts of the following 51 individuals: AF, AG, AHA, AR, BM, CG, DB, DJ, DVP, FA, FR, GA, HJA, HST, IM, JAP, JB, JDM, JEM, JHB, JJM, JR, KAB, KF, LLQ, MAG, MDC, MG, MJM, MM, MIM, ND, NST, ORL, PP, RB, RL, RF, RM, RR, RT, MAG, PP, SEC, SC, SG, SH, SWK, VLP, WDN and WMM 2. List of individuals tested in their primary/preferred languages 3. List of school-age/other individuals needing cognitive and academic assessments within 30 days of admission 4. Standard assessment protocols 5. Cognitive/academic assessments 6. List verifying competence in assessment 7. Psychological Focused Assessments 8. Structural/functional assessments 9. List of senior psychologists' observations of psychological assessments Observed: 1. WRPC for JC (Program 1, Unit 5) 2. WRPC for KDK (Program VI, Unit 71) 3. WRPC for MB (Program VI, Unit 71)

D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals. **Findings:** Information from the Chief of Psychology and documentation review found that PSH has revised the Psychology and By Choice manuals to be aligned with DMH hospitals. The PBS manual is still under revision. The DMH Psychology and By Choice manuals have been completed and are aligned across DMH hospitals. The Psychology Manual is currently being updated. The PBS Manual is undergoing revision and being aligned at the statewide level. **Recommendation 2, June 2008:** Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP. **Findings:** PSH has hired 23 psychologists during this review period, bringing the percentage of filled positions to 93%. PSH is continuing its efforts to fill the remaining 7% vacancy. **Compliance:** Partial. **Current recommendations**: 1. Ensure that revised documents or manuals, where applicable, are aligned across DMH hospitals. 2. Ensure that there are sufficient numbers of psychologists to fulfill all requirements of the EP.

D.2.b	Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** PSH admitted 33 individuals who were 22 years of age and younger. Two (JTJ and MG) of the 33 individuals met the criteria for academic and cognitive assessments. The required assessments were completed for these two individuals but not within the 30-day timeline. In one case (JTJ), caregiver consent for the minor individual was not received before the 30-day timeline, and in the other case (MG), the assessment dates could not be accommodated by the contracting School Psychologist. JTJ's assessments were completed on the 55th day of admission, and MG's assessments were completed on the 33rd day of admission. This monitor found that the facility had an adequate process to ensure compliance with the required timeframes in the absence of confounding factors and that the quality of the assessments met generally accepted standards. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Fill all vacant psychology positions. **Findings:** PSH currently has 93% of its Psychology staffing needs filled and is

working to fill the remaining 7% vacancy.

Recommendation 2, June 2008:
Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff.

Findings:
According to the Chief of Psychology and the Senior Psychologists, the Senior Psychologists have had the time to properly mentor and supervise the psychology staff. Senior Psychologists have been involved in assisting psychology staff in focused assessments, By Choice, WRP processes, behavioral interventions and pre-effective date IAPs. Each of PSH's seven Senior Supervising psychologists allocated three to ten hours per week to the WRP Mentoring Project, providing intensive supervision to unit staff and WRPTs.

Recommendation 3, June 2008:
Ensure that staff is trained on the Psychology Focused Assessment and fully implemented when the instrument receives DMH approval.

Findings:
PSH has 92 psychologists, and all of them meet the facility's credentialing and privileging criteria. The table below shows the number of psychologists responsible for psychological assessments, the number meeting credentials, and the number verified as competent:

1.a	*Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations*	92
1.b	*Number of psychologists who meet the hospital's credentialing and privileging requirements*	92
2.a	*Number of psychologists observed while undertaking psychological assessments*	12

		2.b — *Number observed to be verifiably competent in assessment procedures* — 12 In addition, the Senior Psychologists continue to use the brief PFA checklist to address PFA quality. This monitor's review of the newly hired psychologists curriculum vitae and hospital credentials verified the facility's data. **Compliance:** Partial. **Current recommendations**: 1. Fill all vacant psychology positions. 2. Ensure that senior psychologists have the necessary time to properly mentor and supervise psychology staff. 3. Ensure that staff is trained on the Psychology Focused Assessment and fully implemented when the instrument receives DMH approval.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Substantial.
D.2.d.i	expressly state the clinical question(s) for the assessment;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using item 3 (*Expressly state the clinical question(s) for the assessment*) from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 32% of the

		focused psychology assessments due for the month (May to October 2008), reporting 100% compliance. This monitor reviewed ten Psychological Focused Assessment reports (CG, FR, HJA, LLQ, PP, RB, RT, SC, SH and VLP). All ten reports had stated the clinical question clearly. **Current recommendations**: Continue current practice.
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue with the current practice of including findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations. **Findings:** Using item 4 (*Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations*) from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 32% of the focused assessments due for the month (May to October 2008), reporting 99% compliance. This monitor reviewed ten Psychological Focused Assessment reports (CG, FR, HJA, LLQ, PP, RB, RT, SC, SH and VLP). All ten reports addressed the clinical question, and had sufficient information that addressed the individual's treatment and rehabilitation needs. **Current recommendation**: Continue with the current practice of including findings specifically addressing the clinical question(s), but not limited to diagnoses and

		treatment recommendations.
D.2.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, June 2008:** Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services. **Findings:** Using item 5 (*Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at Mall groups*) from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 32% of the focused assessments due for the month (May to October 2008), reporting 96% compliance. This monitor reviewed ten Psychological Focused Assessment reports (CG, FR, HJA, LLQ, PP, RB, RT, SC, SH and VLP). All ten reports included findings and recommendations pertaining to the individual's participation in therapeutic services. **Current recommendation**: Ensure that all psychological assessments include findings and recommendations pertaining to the individual's participation in therapeutic services.
D.2.d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue and improve on current practice.

		Findings: Using item 6 (*Be based on current, accurate, and complete data*) from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 32% of the focused assessments due for the month (May to October 2008), reporting 98% compliance. This monitor reviewed ten Psychology Focused Assessment reports (CG, FR, HJA, LLQ, PP, RB, RT, SC, SH and VLP). All ten reports included the necessary identifying information, the sources of information, and data from observation of the individual. **Current recommendation**: Continue and improve on current practice.
D.2.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 recommendation:** **Recommendation, June 2008:** Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement. **Findings:** Using item 7 (*Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required*) from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 32% of the focused assessments due for the month (May to October 2008), reporting 98% compliance. This monitor reviewed ten Psychology Focused Assessment reports (CG, FR, HJA, LLQ, PP, RB, RT, SC, SH and VLP). All ten reports addressed whether behavioral supports or interventions were warranted or a full positive behavior support plan was required.

		Current recommendation: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.
D.2.d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using item 8 (*Include the implications of the findings for interventions*) from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 32% of the focused assessments due for the month (May to October 2008), reporting 99% compliance. This monitor reviewed ten Psychology Focused Assessment reports (CG, FR, HJA, LLQ, PP, RB, RT, SC, SH and VLP). All ten reports included the implications of the findings from the assessments for the individual's interventions. **Current recommendation**: Continue current practice.
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that all psychological assessments meet this requirement. **Findings:** Using item 9 (*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) from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 32% of the focused assessments due for the month (May to October 2008), reporting 96% compliance. This monitor reviewed ten Psychology Focused Assessment reports (CG, FR, HJA, LLQ, PP, RB, RT, SC, SH and VLP). All ten reports addressed unresolved issues encompassed by the assessments. **Recommendations 2 and3, June 2008:** • Ensure that WRPTs review and include appropriate recommendations in the individual's WRP. • Ensure that additional workups are completed as requested. **Findings:** According to the Chief of Psychology, the Senior Psychologists mentor twenty treatment teams as part of the hospital-wide WRP Mentoring Project. The need to integrate the psychology focused assessment data into the individual's WRP is emphasized through PSH's Newsletter ("The Bugle"). Teams receive feedback from senior psychologists on proper ways to integrate Neuropsychology focused assessments into the individual's WRP. This monitor reviewed six Psychology Focused Assessment reports (HJA, LLQ, RB, RT, SC and SH). In all cases, information from the assessments was reviewed by the WRPTs, and where indicated, the requested workups were completed. **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.2.d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed. **Findings:** Using item 10 (*Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing*) from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 32% of the focused assessments due for the month (May to October 2008), reporting 98% compliance. This monitor reviewed eight Psychology Focused Assessment reports (HJA, LLQ, PP, RB, RF, RT, SC and SH). All eight reports made use of assessment tools that were appropriate to address the referral questions and for the individuals assessed. **Current recommendation**: Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.
D.2.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	**Current findings on previous recommendations:** **Recommendations 1-3, June 2008:** • Ensure that psychological tests are completed in a timely manner, as specified in the EP. • Ensure that reports meet acceptable quality. • Review all psychological assessments of all individuals residing at

and IV.B.2], above.

PSH who were admitted prior to June 1, 2006, and complete further assessments as required by the EP.

Findings:
According to the Chief of Psychology and the Senior Psychologists, the Psychology Department made it a priority to complete catch-up Integrated Assessments: Psychology Section, and has taken steps to free psychologists to attend to these assessments, including the reduction of Mall facilitation hours (by four hours each week) for the assessment psychologists, providing intense training to newly hired psychologists to bring them up to speed to conduct these assessments, providing timely review and feedback to psychologists if their assessments failed to meet the quality criteria, and having psychologists work 10-hour shifts per week with a significant portion of these hours dedicated to pre-effective-date IAPs.

The table below showing the number of individuals admitted prior to June 1, 2006 still in the facility and requiring a catch-up IAP (N) for the month (May to October 2008), and the number of assessments completed for the month (n) is a summary of the facility's data:

	5/08	6/08	7/08	8/08	9/08	10/08
N	491	426	385	350	311	223
n	65	41	27	44	96	103

PSH has completed review and assessment of over 80% of the pre-effective date IAP assessments. PSH is determined to complete all assessments prior to the next review in June 2009.

PSH also used items 13 and 14 from the DMH Psychology Assessment Monitoring Form to assess its compliance based on a mean sample of 21% of the IAPs completed for the month. The table below is a summary of the data:

<table>
<tr>
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<table>
<tr><td>13.</td><td>Address the nature of the individual's impairments to inform the psychiatric diagnosis</td><td>100%</td></tr>
<tr><td>14.</td><td>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process</td><td>99%</td></tr>
</table>

This monitor reviewed eight charts of individuals admitted to PSH before the effective date (DB, DJ, GA, JDM, KF, MDC, RM and SWK). All eight of them have had their IPAs reviewed and appropriate action has been taken. The completed IPAs were accurate and complete.

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.
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<tr>
<td>D.2.f</td>
<td>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</td>
<td>Compliance:
Partial.</td>
</tr>
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<tr><td></td><td>programming, and, in particular:</td><td></td></tr>
<tr><td>D.2.f.i</td><td>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</td><td>

Current findings on previous recommendation:

Recommendation, June 2008:
Ensure that integrated psychological assessments are conducted in a timely manner as required.

Findings:
Using item 12 from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 90% of the Integrated Assessments due for the month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>12.</td><td>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</td><td>68%</td></tr>
</table>

Comparative data showed improvement in compliance since the last review as follows:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>12.</td><td>47%</td><td>68%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>12.</td><td>44%</td><td>90%</td></tr>
</table>

PSH also reviewed a mean sample of 90% of the untimely/incomplete IPAs to determine if in fact they were eventually completed, reporting mean compliance of 95%. The mean compliance for the previous review period was 75%.

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		PSH attributed improvement in timely IPA completion to three factors: a change in IPA compliance criteria from five days of admission to completion within two or more days before the initial WRPC, providing feedback to examiners through sharing of the PLATO data, and the withdrawal of the requirement to have SRAs completed for all routine admissions. At the same time, a number of factors including staff vacancy rate, reduced staff work time due to pregnancy, and the priority to complete assessments of pre-effective-date admission IPAs were barriers to higher compliance rates. As plan of corrective action: PSH has plans to open up a seventh admissions unit, assign staff relieved from pre-effective-date admission assessments to conduct IPA assessments, and use the newly streamlined IPA template. This monitor reviewed nine charts (AF, AHA, CG, DVP, JJM, MJM, MM, RM and VLP). Six of the IPAs in the charts (CG, DVP, MJM, MM, RM and VLP) were timely. The remaining three (AF, AHA and JJM) were untimely. **Current recommendation**: Ensure that integrated psychological assessments are conducted in a timely manner as required.
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis **Findings:** Using item 13 from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of

<table>
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<td>the Integrated Assessments completed that were due for the month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>13.</td><td>Address the nature of the individual's impairments to inform the psychiatric diagnosis</td><td>100%</td></tr>
</table>

The mean compliance rate for the previous review period was 89%.

This monitor reviewed eight charts (AF, AHA, CG, DVP, JJM, MJM, MM and RM). Seven of the Integrated Assessments in the charts (AF, AHA, CG, DVP, JJM, MJM and RM) provided information to inform the psychiatric diagnosis, including the nature and extent of signs and symptoms and their excesses and deficits, and one of them (MM) did not meet the criteria.

Current recommendation:
Ensure that integrated psychological assessments address the nature of the individual's impairments that inform the psychiatric diagnosis.</td>
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<tr>
<td>D.2.f.i.2</td>
<td>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</td>
<td>Current findings on previous recommendation:

Recommendation, June 2008:
Ensure accurate and complete evaluation of an individual's psychological functioning that informs the WRPTs of the individual's rehabilitation service needs.

Findings:
Using item 14 from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments due for the month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>14.</td><td>Provide an accurate evaluation of the individual's</td><td>92%</td></tr>
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		psychological functioning to inform the therapeutic and rehabilitation service planning process. The mean compliance for the previous review period was 93%. This monitor reviewed eight charts (AF, AHA, CG, DVP, JJM, MJM, MM and RM). Seven of the Integrated Assessments in the charts (AF, AHA, CG, DVP, JJM, MJM and RM) provided an accurate evaluation of the individual's psychological functioning that the WRPT can use to determine the nature of the individual's rehabilitation services, and one of them (MM) did not provide sufficient information to fully address this recommendation. **Current recommendation**: Ensure accurate and complete evaluation of an individual's psychological functioning that informs the WRPTs of the individual's rehabilitation service needs.
D.2.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 recommendation:** **Recommendation, June 2008:** Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors. **Findings:** This monitor's documentation review (progress report, PBS plans and structural and functional assessments), interview of Psychology staff, and attendance at PSH's Psychology Specialized Services Committee meeting found that the PBS teams responded to referrals within 24 hours or within two working days (for referrals coming in at the end of the week). Referrals were discussed at the Psychology Specialized Services Committee meetings (the PSSC meets twice weekly) and timely and appropriate actions had been taken on individuals with

maladaptive behaviors.

5.	*PBS assessments include structural and functional assessments, and as necessary, functional analysis*	100%
5.a	*Pertinent records were reviewed (e.g., individual's chart/record, meeting notes, anecdotal records, evaluations, previous interventions),*	100%
5.b	*Structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,*	100%
5.c	*Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.*	100%
5.d	*Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,*	100%
5.e	*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, as needed, and*	100%
5.f	*If necessary, suspected maintaining variables were manipulated to assess the motivation(s) for the individual's behavior.*	100%

As the table above shows, and this monitor's review of the structural and functional assessments verified, the PBS teams had conducted structural and functional assessments prior to developing and

<table>
<tr><td></td><td></td><td>implementing PBS plans. The mean compliance rate for the previous review period was 95%.

Current recommendation:
Ensure that PBS referrals get timely attention to assist unit staff to manage individuals with significant learned maladaptive behaviors.</td></tr>
<tr><td>D.2.f.iii</td><td>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.</td><td>Current findings on previous recommendations:

Recommendation 1, June 2008:
Ensure that additional psychological assessments are performed as required.

Findings:
According to the Chief of Psychology, Senior Psychologists trained and mentored unit psychologists regarding additional assessments to address unresolved clinical or diagnostic questions. In addition, PSH has integrated the DSM-IV-TR checklist electronically, and that has allowed psychologists to complete the checklists routinely.

Using items 16-20 from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 55% of additional assessments due for the month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>16</td><td>Differential diagnosis</td><td>56%</td></tr>
<tr><td>17.</td><td>Rule-out</td><td>30%</td></tr>
<tr><td>18.</td><td>Deferred</td><td>45%</td></tr>
<tr><td>19.</td><td>No diagnosis</td><td>95%</td></tr>
<tr><td>20.</td><td>NOS diagnosis</td><td>25%</td></tr>
</table>

Comparative data showed mixed changes in compliance since the last review as follows:</td></tr>
</table>

	Previous period	Current period
Mean compliance rate		
16. *Differential diagnosis*	65%	56%
17. *Rule-out*	31%	30%
18. *Deferred*	31%	45%
19. *No diagnosis*	90%	95%
20. *NOS diagnosis*	35%	25%

The sample sizes used in the prior period ranged from 4% to 10%, while a 55% sample was used in the current period.

According to the Chief of Psychology, staffing shortage, frequent movement of individuals from admission units to ICF unit or to court, and lack of space to conduct testing created a difficult situation to complete higher rates of follow-up assessments.

As a plan for corrective action, PSH intends to add resources to enable staff to complete assessments in a timely manner. A seventh admission unit is to be opened to allow for more testing time. In addition, individuals who do not require follow-up assessments as in the case of those returning from court and those unwilling to participate in additional assessments would be identified to free up staff time to conduct the required assessments.

This monitor reviewed 14 charts of individuals with diagnostic uncertainties (AG, AR, FA, HST, JB, JEM, KAB, MAG, MG, ND, RF, RR, SEC and WDN). Additional assessments were completed for seven of them (AG, AR, HST, JB, MG, SEC and WDN), and the remaining seven (FA, JEM, KAB, MAG, ND, RF and RR) did not have the required follow-up assessments completed.

		Recommendation 2, June 2008: 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:** According to the Chief of Psychology, the DSM-IV-TR Checklist is aligned with the requirement that "no diagnosis" is backed up by clinical data. The DSM-IV-TR Checklist is available electronically and hard copies are distributed to all staff conducting the assessments. Training on how to achieve compliance and in the use of the DSM-IV-TR Checklist is conducted during the New Psychologist Seminar. This monitor reviewed three psychological assessments (MG, ND, and NST) and all three had conducted the required follow-up assessments to clarify the diagnoses. **Recommendation 3, June 2008:** Ensure that supporting documents are recorded and referenced when using previous assessment results to address diagnosis-related matters. **Findings:** This monitor's interview of the Chief of Psychology found that PSH continues to train staff on proper referencing of documents when using previous assessment results to address diagnosis-related matters. A training session was conducted in September 2008 for this purpose. Mentors review the assessments to ensure that proper documentation is followed. PSH also opened an Assessment Center that will train staff in a uniformed manner. All psychological assessments reviewed by this monitor (AG, AR, HST, JB, MG, SEC and WDN) had conducted follow-up assessments (using

		mainly the DSM-IV-TR checklists) to clarify the diagnosis. **Current recommendations**: 1. Ensure that additional psychological assessments are performed as required. 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.
D.2.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 language and dialect, if feasible.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that assessments conducted meet the requirement of this cell. **Findings:** According to the Chief of Psychology, PSH hired five bilingual psychologists during this review period, bringing the number of bilingual psychologists at PSH to 18. PSH has continued to train psychologists in the proper assessments of individuals whose primary/preferred language is other than English. Using items 21-23 from the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the individuals admitted during this review period (May to October 2008) whose preferred/primary language is other than English. The table below with its indicators and sub-indicators and the number of individuals meeting criteria in each category is a summary of the data:

21.a	*Number of individuals who needed assessment during the evaluation period whose primary language was not English*	19
21.b	*Of those in 21.a, number of individuals who were assessed in their primary language*	15
22.a	*Of those in 21.a, number of individuals who could not be assessed*	4
22.b	*Of those in 22.a, number of individuals who had plans developed to meet their assessment needs*	4
23.	*Of those in 22.b, number of individuals whose plans for assessment were implemented*	4

As shown in the table above, PSH followed the requirements in assessing individuals whose primary/preferred language is other than English. The mean compliance rate for this review period is 100%, compared to 74% in the previous review period.

This monitor reviewed 10 charts (AHA, BM, IM, JHB, JR, ORL, RL, RR, SG and WMM) of individuals whose primary/preferred language is other than English. All 10 of them were assessed in their primary/preferred language. In most cases, the individuals' primary/preferred language was Spanish, and PSH used one of its Spanish-speaking staff to conduct the assessments. One of the individuals (WMM) used ASL, and the staff conducting the assessments was certified in ASL. In the case of AHA, PSH had provided a translator in Somali because he had asked for one, even though he was competent in the English language. Where necessary, the staff used testing instruments in the individual's primary/preferred language (for example, ORL and IM). The staff also indicated in the reports if the individuals could participate in Mall group/court competency in English or needed specific language groups.

		Compliance: Substantial. **Current recommendation**: Ensure that assessments conducted meet the requirement of this cell.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Charles Allen, Nursing Coordinator Program, VI 2. Diana Jean Walayat, RN 3. George Fedorka, RN, Admission Suite 4. Gwendeline Init, RN 5. James Jordan, Unit Supervisor, Admission Suite 6. Kathy Wood, Nursing Coordinator, Program VI 7. Lidia Lau, Assistant Coordinator of Nursing Services 8. Regina Olender, Nurse Administrator 9. Tatiana Rojas, RN, Auditor 10. Tu Lim, RN, Admission Suite Reviewed: 1. PSH's progress report and data 2. Enhancement Plan of Action Tracking Sheet 3. Memo dated 8/4/08, Admission Suite and the Nursing Admission Assessment Proposal 4. PSH training rosters for Admission and Integrated Nursing Assessments and WRP Level 1 Training 5. Admission Nursing Assessment RN Competency Evaluation 6. Memo dated 9/15/08 regarding attendance of nursing staff at the WRPCs 7. Memo dated 9/18/08, RN and PT Participation in the WRP Conference 8. Medical records for the following 43 individuals: AEG, AER, AJ, BGM, CH, CLR, CT, DAC, DMZ, DO, EA, EBW, EDL, GF, GH, GMM, HAB, JCS, JHB, JP, JSC, JWP, LLJ, LRO, MCB, MEM, MGD, MRO, MRR, NB, ND, OFL, PM, PWM, RDH, RJ, RPR, RSB, RWM, TEL, TOM, WPN and WRW

		Observed: 1. WRPC on Program IV, Unit 36 2. WRPC on Program VI, Unit EB-09
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Partial.
D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Admission Assessment Monitoring audit for EP cells D.3.a.i-D.3.a.ix based on an average 99% sample of admissions for the month (May-October 2008), PSH reported the following data for this requirement:

1.	*A description of presenting conditions*	6%
1.a	*Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete*	32%
1.b	*Each box checked is elaborated on in the narrative description in the summary of presenting conditions*	8%
1.c	*The narrative description of the individual is described in recovery language and when possible from the individual's perspective*	88%
2.	*Current prescribed medications*	49%
2.a	*In the additional comments section there is documentation that medication records are not available and the individual is unable to provide*	49%

	information about past medication history	
3.	*Vital signs are fully documented or there is documentation that the individual was non-adherent*	94%
4.	*Allergies*	90%
4.a	*Box for no known allergies checked*	100%
4.b	*If the individual is assessed to have allergies, include type of allergy, source of information, and a description of the signs and symptoms*	71%
5.	*Pain - All applicable sections of the Pain Assessment are completed*	68%
6.	*Use of assistive devices*	54%
6.a	*Vision*	90%
6.b	*Sleep*	89%
6.c	*Hearing*	84%
6.d	*Eating*	87%
6.e	*Teeth*	87%
6.f	*Speech*	75%
6.g	*Additional assistive devices*	67%
7.	*Activities of daily living*	88%
7.a	*The entire ADL section is complete*	96%
7.b	*Any rating of 1 or greater is elaborated on in the comments section*	8%
8.	*Immediate alerts*	89%
8.a	*None known box is checked*	80%
8.b	*Alerts section is completed*	79%
9.	*For conditions needing immediate nursing interventions there are immediate nursing interventions documented*	9%
9.a	*If alerts/risks checked, there are immediate nursing interventions documented*	9%

PSH's comparison data for item 1 is presented below:

	Previous period	Current period
Mean compliance rate		
1.	1%	6%
Compliance rate in last month of period		
1.	3%	16%
1.a	14%	48%
1.b	4%	30%
1.c	68%	98%

PSH's progress report indicated that although there has been an overall increase in the compliance scores (with the exceptions of items 8 and 9), the RNs are not completing all sections of the admission assessments. In response to issues regarding D.3.a.i-D.3.ix for both admission and integrated assessments, the facility implemented the Admission Suite Project in September 2008; to maintain consistency, the Project mandates that all admission nursing assessments are conducted in the Admission Suite before the individual is transferred to the unit. In cases in which the assessment cannot be completed in the Admission Suite, the RN will accompany the individual to the unit to complete the assessment. RNs identified as skilled in assessment have been selected for the Admission Suite. In addition, the facility has implemented RN staffing projections to ensure adequate staffing to accommodate the number of admissions. Also, training based on audit findings was developed and implemented in October 2008 emphasizing the assessment sections in low compliance. PSH's progress report also indicated that the overall increase in compliance for the admission and integrated assessments was due to centralizing admissions in the Admission Suite. PSH's comparison data for each item is presented in cells D.3.a.i-D.3.ix.

A review of the admission assessments of 43 individuals (AEG, AER, AJ,

BGM, CH, CLR, CT, DAC, DMZ, DO, EA, EBW, EDL, GF, GH, GMM, HAB, JCS, JHB, JP, JSC, JWP, LLJ, LRO, MCB, MEM, MGD, MRO, MRR, NB, ND, OFL, PM, PWM, RDH, RJ, RPR, RSB, RWM, TEL, TOM, WPN and WRW) found that there were significant problematic issues in all the assessments. For a majority of the assessments, the presenting condition consisted of a list of the individual's charges with little to no narrative description. There were major unexplained inconsistencies and discrepancies noted within the information in a number of the assessments. Also, many health issues that were identified were not adequately addressed or included in the body systems section of the assessments. Much of the information contained in the assessments did not reflect the clinical relevance of the questions on the assessment form. In addition, a number of goals did not reflect the information found in the assessments, and in some cases, actually contradicted the information. A number of assessments contained incomplete information regarding medications. All of the assessments reviewed did include vital signs, and allergies. Although PSH's compliance scores indicated an increase in questions answered on the RN Admission Assessments, the information contained in most of the assessments reviewed was inadequate.

Using the DMH Nursing Integrated Assessment Monitoring audit for EP cells D.3.a.i-D.3.a.ix, based on an average sample of 94% of integrated assessments for the month (May-October 2008), PSH reported the following data for this requirement:

1.	*A description of presenting conditions*	61%
1.a	*Each section of the Psychiatric and Psychological section of the Nursing Assessment is complete*	66%
1.b	*Each box checked is elaborated on in the narrative description in the summary of presenting conditions*	47%
1.c	*The narrative description of the individual is*	95%

			described in recovery language and when possible from the individual's perspective	
		2.	*Current prescribed medications*	90%
		2.a	*In the additional comments section there is documentation that medication records are not available and the individual is unable to provide information about past medication history*	33%
		2.b	*All sections of the medication management section are completed*	92%
		2.c	*Include, when possible, individual's perception of medication regimen or side effects to watch for*	93%
		3.	*Vital signs are fully documented or there is documentation that the individual was non-adherent*	84%
		4.	*Allergies*	94%
		4.a	*Box for no known allergies checked*	99%
		4.b	*If the individual is assessed to have allergies, (include type of allergy, source of information, and a description of the signs and symptoms)*	98%
		4.c	*Source of information*	82%
		4.d	*Description of signs and symptoms*	89%
		5.	*Pain - All applicable sections of the Pain Assessment are completed*	62%
		6.	*Use of assistive devices*	86%
		6.a	*The no problems box is checked*	86%
		6.b	*Assistive devices section is completed (if applicable)*	21%
		7.	*Activities of daily living*	46%
		7.a	*The entire ADL section is complete*	51%
		7.b	*Any rating of 1 or greater is elaborated on in the comments section*	0%
		8.	*Immediate alerts*	94%
		8.a	*None known box is checked*	91%

8.b	*Alerts section is completed*	86%
9.	*For conditions needing immediate nursing interventions there are immediate nursing interventions documented*	20%
9.a	*If alerts/risks checked there are immediate nursing interventions documented*	20%

PSH's comparison data for item 1 is presented below:

	Previous period	Current period
Mean compliance rate		
1.	16%	61%
Compliance rate in last month of period		
1.	43%	76%
1.a	46%	79%
1.b	41%	64%
1.c	81%	97%

Overall compliance rates increased for most items pertaining to integrated assessments, but remain low for a number of items. The continued low compliance is attributable to sub-items being left blank.

A review of integrated assessments for 43 individuals (AEG, AER, AJ, BGM, CH, CLR, CT, DAC, DMZ, DO, EA, EBW, EDL, GF, GH, GMM, HAB, JCS, JHB, JP, JSC, JWP, LLJ, LRO, MCB, MEM, MGD, MRO, MRR, NB, ND, OFL, PM, PWM, RDH, RJ, RPR, RSB, RWM, TEL, TOM, WPN and WRW) found that a number of the integrated assessments contained the same problematic issues as described above in the initial nursing assessments since much of the information was the same. The inconsistencies and discrepancies rendered much of the information found in the integrated assessments inadequate. However, all of the integrated assessments reviewed did include vital signs and allergies.

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Other findings:
From discussion with Nursing, there appears to be a lack of understanding regarding what type of information should be addressed in the Admission and Integrated Assessments. Completing these assessments is more than merely a question-and-answer session between the RN and the individual. A better understanding of the clinical relevance of the questions contained in the admission/integrated assessment is needed.

Current recommendations:
1. Ensure compliance scores accurately reflect items being reviewed.
2. Include the clinical relevance of questions contained in the admission and integrated assessments in RN training.
3. Continue to monitor this requirement.

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<tr>
<td>D.3.a.ii</td>
<td>current prescribed medications;</td>
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<u>Admission Assessments</u>

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.</td><td>32%</td><td>49%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>28%</td><td>88%</td></tr>
<tr><td>2.a</td><td>28%</td><td>88%</td></tr>
</table>

<u>Integrated Assessments</u>

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.</td><td>38%</td><td>90%</td></tr>
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<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>62%</td><td>93%</td></tr>
<tr><td>2.a</td><td>33%</td><td>N/A</td></tr>
<tr><td>2.b</td><td>78%</td><td>99%</td></tr>
<tr><td></td><td>73%</td><td>92%</td></tr>
</table>

Comparison data showed an increase in compliance since the last review.
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<tr>
<td>D.3.a.iii</td>
<td>vital signs;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>3.</td><td>83%</td><td>94%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>3.</td><td>82%</td><td>100%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>3.</td><td>36%</td><td>84%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>3.</td><td>70%</td><td>90%</td></tr>
</table>

Comparison data showed an increase in compliance since the last review.
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D.3.a.iv	allergies;	Admission Assessments Previous period / Current period Mean compliance rate 4. 71% 90% Compliance rate in last month of period 4. 81% 99% 4.a 97% 100% 4.b 50% 97% Integrated Assessments Previous period / Current period Mean compliance rate 4. 42% 94% 4. 92% 97% 4.a 96% 98% 4.b 89% 96% 4.c 78% 92% 4.d 78% 92% Comparison data showed an increase in compliance since the last review.
D.3.a.v	pain;	Admission Assessments Previous period / Current period Mean compliance rate 5. 63% 68%

	Previous period	Current period
Compliance rate in last month of period		
5.	62%	92%

Integrated Assessments

	Previous period	Current period
Mean compliance rate		
5.	27%	62%
Compliance rate in last month of period		
5.	60%	72%

Comparison data showed an increase in compliance since the last review.

D.3.a.vi

use of assistive devices;

Admission Assessments

	Previous period	Current period
Mean compliance rate		
6.	34%	54%
Compliance rate in last month of period		
6.	48%	79%
6.a	87%	99%
6.b	83%	98%
6.c	74%	98%
6.d	73%	96%
6.e	78%	97%
6.f	68%	87%
6.g	62%	87%

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<u>Integrated Assessments</u>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.</td><td>31%</td><td>86%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.</td><td>60%</td><td>87%</td></tr>
<tr><td>6.a</td><td>60%</td><td>86%</td></tr>
<tr><td>6.b</td><td>0%</td><td>21%</td></tr>
</table>
Comparison data showed an increase in compliance since the last review.
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<tr>
<td>D.3.a.vii</td>
<td>activities of daily living;</td>
<td>
<u>Admission Assessments</u>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>78%</td><td>88%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>92%</td><td>96%</td></tr>
<tr><td>7.a</td><td>94%</td><td>98%</td></tr>
<tr><td>7.b</td><td>0%</td><td>0%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>17%</td><td>46%</td></tr>
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</table>

	Previous period	Current period
Compliance rate in last month of period		
7.	46%	51%
7.a	51%	57%
7.b	33%	0%

Comparison data showed an increase in compliance since the last review with the exception of item 7.b.

D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	

<u>Admission Assessments</u>

	Previous period	Current period
Mean compliance rate		
8.	91%	89%
Compliance rate in last month of period		
8.	92%	92%
8.a	78%	90%
8.b	89%	74%

<u>Integrated Assessments</u>

	Previous period	Current period
Mean compliance rate		
8.	42%	94%
Compliance rate in last month of period		
8.	79%	96%
8.a	53%	95%
8.b	76%	75%

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<tr><td></td><td></td><td>Comparison data demonstrated mixed changes since the last review. PSH's progress report indicated that the RNs had misinterpreted the question, thinking it meant "any history" of alerts rather than an immediate and current alert. Training has been provided to clarify this issue.</td></tr>
<tr><td>D.3.a.ix</td><td>conditions needing immediate nursing interventions.</td><td>
<u>Admission Assessments</u>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>9.</td><td>9%</td><td>9%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>9.</td><td>8%</td><td>22%</td></tr>
<tr><td>9.a</td><td>8%</td><td>22%</td></tr>
</table>
<u>Integrated Assessments</u>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>9.</td><td>8%</td><td>20%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>9.</td><td>17%</td><td>10%</td></tr>
</table>
Comparison data demonstrated some increases in compliance. The RNs were misinterpreting this section as noted in D.3.a.viii.
</td></tr>
<tr><td>D.3.b</td><td>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</td><td>Current findings on previous recommendation:</td></tr>
</table>

		Recommendation, June 2008: Continue current practice. **Findings:** PSH's Nursing Department Policy and Procedures and assessment tools verify that PSH is consistently using the Wellness and Recovery Model for Nursing. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at state facilities 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 recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH's training rosters demonstrated and verified that as of October 2008, 401 RNs (95%) have received and passed the Admission and Integrated Assessment training and competency test. Only 15 RNs still need to be trained. Although 95% of the nurses have received training regarding Nursing Assessments, the quality of the assessments reviewed during the tour was generally poor, however. **Compliance:** Partial. **Current recommendation**: Continue current practice.

D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	**Compliance:** Partial.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendation:** **Recommendation, June 2008:** See D.3.a.i. **Findings:** PSH used the DMH Nursing Admission Assessment Monitoring based on a 99% average sample of admissions for the month (May-October 2008) to assess compliance, reporting the following data: 12. *Initial nursing assessments are completed within 24 hours of the individual's admission* 95% Mean compliance for this requirement in the previous review period was 88%. A review of nursing admission assessments for 43 individuals (AEG, AER, AJ, BGM, CH, CLR, CT, DAC, DMZ, DO, EA, EBW, EDL, GF, GH, GMM, HAB, JCS, JHB, JP, JSC, JWP, LLJ, LRO, MCB, MEM, MGD, MRO, MRR, NB, ND, OFL, PM, PWM, RDH, RJ, RPR, RSB, RWM, TEL, TOM, WPN and WRW) found that 18 were timely completed, eight were not timely completed and 17 did not have the "Sections Completed" area filled out to accurately determine timeliness. **Current recommendations**: 1. Ensure that the "Sections Completed" area is appropriately completed. 2. Continue to monitor this requirement.

D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH used the DMH Nursing Integrated Assessment Monitoring based on a 94% average sample of integrated assessments for the month (May-October 2008), reporting the following data:

13.	*Further Nursing Assessments*	29%
13.a	*Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission*	65%
13.b	*The Integrated Nursing Assessment is completed between (3) to (5) days of admission*	29%

PSH's data analysis is presented in the table below:

	Previous period	Current period
Mean compliance rate		
13.	16%	29%
Compliance rate in last month of period		
13.	19%	45%
13.a	N/A	N/A
13.b	19%	45%

Aside from noting that item 13.b decreased the overall compliance score for this item, no other barrier to compliance was presented by PSH. In September 2008, the facility implemented an RN to provide in-service training and guidance to the RNs. PSH also indicated that the Nurse

		Administrator now provides the nursing supervisors with the compliance scores for their staffs. The HSSs will be reviewing these with the RNs. A review of integrated assessments for 43 individuals (AEG, AER, AJ, BGM, CH, CLR, CT, DAC, DMZ, DO, EA, EBW, EDL, GF, GH, GMM, HAB, JCS, JHB, JP, JSC, JWP, LLJ, LRO, MCB, MEM, MGD, MRO, MRR, NB, ND, OFL, PM, PWM, RDH, RJ, RPR, RSB, RWM, TEL, TOM, WPN and WRW) found that 17 were timely completed and 26 were not timely completed. **Current recommendation**: Continue to monitor this requirement.
D.3.d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH used the DMH WRP Observation Monitoring Form based on an 11% average sample of WRPCs due in the review months (May-October 2008), reporting the following data: 1. *The Registered Nurse participates by presenting or updating discipline-specific and/or holistic assessment data* — 51% Compliance for this item increased from 30% in the last review period to 51% in the current period. PSH indicated that RN and PT attendance at the WRPCs remain low. The facility has developed an "RN and PT Participation at the WRPC Checklist" to ensure that RNs and PTs are prepared to present at the conference. The Checklist is kept with the Conference Coordinator in case a substitute RN or PT has to attend the

conference.

In observations of two WRPCs (Program IV, Unit 36 and Program VI, Unit EB09), this reviewer found that little information was provided by the nurse in either WRPC and that the brief reviews of the nursing assessments did not relate to the individuals' WRP objectives.

Other findings:
PSH used the DMH WRP Observation Monitoring Form based on an 11% average sample of WRPCs due in the review months (May-October 2008), reporting the following data:

1.	*Registered Nurse attendance at WRPC*	83%
2.	*Psychiatric Technician attendance at WRPC*	48%

PSH's data analysis showed an increase from 23% and 7% to 83% and 48% of RN and PT attendance at WRPC, respectively. However, PSH indicated that the Shift Leads have not been consistent in ensuring attendance at the WRPCs. The facility's plan to improve compliance indicated that the Medical Director and Clinical Administrator distributed a joint memo to the physicians and Program Directors addressing attendance of the RN and PT at all conferences. This issue is also being addressed at supervisors' meetings. In addition, the Unit Supervisors are now reviewing the shift schedule to ensure RN/PT attendance at the conferences.

Current recommendation:
Continue to monitor this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Alejandro Fernandez, Senior Rehabilitation Therapist 2. Billy Mange, Senior Vocational Rehabilitation Counselor 3. Curt Peters, Senior Rehabilitation Therapist 4. Debra Taylor-Tatum, Senior Rehabilitation Therapist 5. Denise Byerly, Nurse Instructor 6. Greg Siples, Chief of Rehabilitation Therapy Services 7. Jack Baum, Senior Vocational Rehabilitation Counselor 8. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist 9. Jay Gehrke, Industrial Therapist 10. Mark Camero, Senior Rehabilitation Therapist 11. Mike Gomes, Senior Rehabilitation Therapist 12. Stan Hydinger, Senior Rehabilitation Therapist Reviewed: 1. DMH Rehabilitation Therapy Service Manual draft 2. DMH Rehabilitation Therapy Monitoring Form and Instructions (D.4 monitoring tool for admission and focused assessments) 3. DMH Rehabilitation Therapy IA-RTS audit data for May-October 2008 4. Focused assessment audit data for May-October 2008 for Speech Therapy, Vocational Rehabilitation and Physical Therapy 5. DMH Vocational Rehabilitation Assessment Monitoring Tool and Instructions 6. Vocational Rehabilitation Screening Tool 7. DMH Occupational Therapy Focused Assessment Monitoring Tool and Instructions 8. DMH Physical Therapy Focused Assessment Monitoring Tool and Instructions 9. DMH Comprehensive Integrated Physical Rehabilitation Therapy

		Assessment Monitoring Tool and Instructions 10. List of individuals who had IA-RTS assessments from May-October 2008 11. Records of the following 17 individuals who had IA-RTS assessments from May-October 2008: BLG, CHF, DDP, EF, EJM, EWM, HAB, JAH, LMG, MAV, MG, MSF, RE, RF, RM, SGM and SR 12. List of individuals with Vocational Rehabilitation assessment in May-October 2008 13. Records for the following eight individuals who had Vocational Rehabilitation Assessments from May-October 2008: DNW, FLL, JTJ, LMB, MDB, MLW, RAD and VDM 14. List of individuals with Physical Therapy assessment in May-October 2008 15. Records for the following five individuals with Physical Therapy assessment in May-October 2008: BKP, DFV, DMZ, JH and KCO 16. List of individuals with Speech Therapy assessment in May-October 2008 17. Records for the following six individuals with Speech Therapy assessment in May-October 2008: AKK, JP, MH, MLB, OD and WHG 18. List of individuals with Occupational Therapy assessment in May-October 2008 19. Records for the following eight individuals with Occupational Therapy assessment in May-October 2008: CT, MJG, MMV, NYC, PC, RC, SSM and YMW 20. List of individuals with Comprehensive Integrated Physical Rehabilitation Therapy assessment in May-October 2008 21. Records for the following individuals with Comprehensive Integrated Physical Rehabilitation Therapy assessment in May-October 2008: DB, DS, RLE and RR 22. List of individuals who had type D.4.d assessments from May-October 2008 23. Records of the following 12 individuals who had type D.4.d

		assessments from May-October 2008: DRL, EW, JBM, KAM, MLM, RDP, RJS, RMM, RW, WDW, YMH and YTP 24. POST Services Referral form 25. Training rosters and post tests for Rehabilitation Therapy focused assessment trainings and IA-RTS trainings 26. Training materials and roster for POST referral training to medical staff 27. Training rosters for Vocational Rehabilitation screening form and process
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Revise and implement the Department of Mental Health Rehabilitation Therapy Service Manual draft based on changes, new protocols and procedures and system development; ensure that all discipline-specific service procedures and manuals are integrated into and consistent with Rehabilitation Therapy practice in relation to the Wellness and Recovery model and EP requirements. **Findings:** The draft of the statewide Rehabilitation Therapy Manual has been subsequently updated as procedures and processes have evolved. The current draft addresses the role of the Rehabilitation Therapist in the WRPT, as well as the role of the RIAT team, POST team, Occupational Therapist, Physical Therapist, Speech Therapist, and Vocational Rehabilitation Counselors and Instructors. The manual includes the Rehabilitation Therapist's role in acting as a liaison to report findings of the POST disciplines and Vocational Rehabilitation Services, as well as information related to 24-hour support plans and discipline-specific progress notes. The final draft is pending statewide finalization, approval and implementation. The Manual should continue to be updated as procedures and systems develop.

		Recommendation 2, June 2008: Develop and implement a plan to ensure that individuals (both new admissions and individuals residing at PSH) who would benefit from a Comprehensive Physical Rehabilitation Therapy assessment or a Vocational Rehabilitation assessment are referred for this service by the WRPT. **Findings:** The proposed referral form for Physical Rehabilitation Therapy focused assessments (including the CIPRTA) was implemented in October 2008. Seventeen members of the medical staff were trained regarding the use and purpose of the form on 10/01/08; this was verified by review of training roster and training materials. Physical Rehabilitation (POST) referral forms were distributed to all nursing staff but no formal training was conducted for nurses regarding this process. **Recommendation 3, June 2008:** Revise and implement the Vocational Rehabilitation screening tool to ensure a more comprehensive tool for Vocational Rehabilitation referrals. **Findings:** Fifty-one out of 73 Rehabilitation Therapy staff were trained to competency on materials related to the Vocational Screening process on 10/29/08; this was verified by review of training rosters and post-tests. The final DMH-approved Vocational Services Screening form was implemented November 1, 2008. However, the Senior Vocational Rehabilitation Counselor reported that currently, the Vocational Rehabilitation staff have been receiving referrals when not appropriate (e.g., when an individual is not medically stable). It appears that education to the WRPTs is needed to ensure that referrals are made

		when appropriate. **Other findings:** It was noted upon review of Vocational Rehabilitation assessments and audit data that no standardized assessments have been used to contribute to assessment objective findings. The facility reported that a plan to recruit a teacher to work within Vocational Rehabilitation in order to complete CASAS standardized assessments has been initiated to provide information regarding educational status and vocational assessment. In addition, the facility reported that it has planned to initiate the Careerscope standardized assessment battery to supplement the Vocational Rehabilitation assessment findings. Previously, there was no liaison between Patton Vocational Rehabilitation Services and the Department of Rehabilitation to ensure that individuals received a thorough Vocational Discharge Summary assessment prior to discharge to the community. The facility reported that this position was filled 3-4 months ago, and there is now ongoing communication with the Department of Rehabilitation to ensure that these assessments will be completed as needed. In addition, it is reported that CONREP is now providing potential discharge lists to the Vocational Rehabilitation staff to prompt the initiation of the Vocational Discharge Summary process for individuals who may require it. **Compliance:** Partial. **Current recommendations**: 1. Implement the Department of Mental Health Rehabilitation Therapy Service Manual draft and revise as needed based on changes, new protocols and procedures, and system development; ensure that all discipline specific service procedures and manuals

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<td>continue to be consistent with Rehabilitation Therapy practice in relation to Wellness and Recovery model and Enhancement Plan requirements.
2. Utilize standardized assessments (e.g. Careerscope) when available as part of the vocational rehabilitation focused assessments as clinically indicated.</td>
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<tr>
<td>D.4.b</td>
<td>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</td>
<td>
Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 99% of Integrated Rehabilitation Therapy assessments due each month for the review period of May-October 2008 (total of 591 out of 596). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:
<table>
<tr><td>1.</td><td>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</td><td>98%</td></tr>
<tr><td>1.a</td><td>The assessment was completed within five calendar days of the individual's admission, and</td><td>98%</td></tr>
<tr><td>1.b</td><td>Filed in the medical record</td><td>99%</td></tr>
</table>
The mean compliance rate for item 1 was 98% in the current review period, compared to 93% in the previous review period.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 63% of Vocational Rehabilitation assessments due each month for the review period of May-October 2008 (total of 20 out of 32). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:
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1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 5 calendar days of the individual's admission, and*	30%
1.b	*Filed in the medical record*	75%

No comparable data were available from the previous review period. The facility analyzed the data and attributed poor timeliness of assessment completion to lack of resources to complete the VRAT assessments. The facility plan of correction is to increase the number of staff who complete VRAT assessments from one to four.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 90% of Speech Therapy assessments due each month for the review period of May-October 2008 (total of 30 out of 32). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 5 calendar days of the individual's admission, and*	90%
1.b	*Filed in the medical record*	90%

No comparable data were available from the previous review period, as the assessment was implemented in April 2008.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool,

PSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy assessments due each month for the review period of May-October 2008 (total of136). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 5 calendar days of the individual's admission, and*	5%
1.b	*Filed in the medical record*	5%

No comparable data were available from the previous review period. The facility analyzed the data and attributed poor timeliness of assessment completion to the lack of a full-time Physical Therapist, which inhibits assessment completion in a timely manner. The facility plan of correction is to hire a full-time Physical Therapist and hire the current part-time Physical Therapist to a full-time position.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 88% of Occupational Therapy assessments due each month for the review period of May-October 2008 (total of 36 out of 41). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 5 calendar*	92%

	days of the individual's admission, and	
1.b	*Filed in the medical record*	95%

No comparable data were available from the previous review period.

Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of May-October 2008 (total of 7). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:*	
1.a	*The assessment was completed within 5 calendar days of the individual's admission, and*	86%
1.b	*Filed in the medical record*	100%

No comparable data were available from the previous review period. The facility analyzed the data and attributed poor timeliness of assessment completion to one late assessment that impacted overall percentage of compliance. Based on the improvement trend noted, continued mentoring will occur to attain substantial compliance over the next reporting period.

Other findings:
A review of the records of seventeen individuals (BLG, CHF, DDP, EF, EJM, EWM, HAB, JAH, LMG, MAV, MG, MSF, RE, RF, RM, SGM and SR) to assess compliance with timeliness of IA-RTS assessments found all records in compliance.

		A review of the records of eight individuals (DNW, FLL, JTJ, LMB, MDB, MLW, RAD and VDM) to assess compliance with timeliness of Vocational Rehabilitation assessments found that none of the eight were in compliance as none of the assessments were filed in the records. A review of the records of five individuals (BKP, DFV, DMZ, JH and KCO) to assess compliance with timeliness of Physical Therapy assessments found one record (DFV) in compliance and four records (BKP, KCO, JH, DMZ) not in compliance. A review of the records of six individuals (AKK, JP, MH, MLB, OD and WHG) to assess compliance with timeliness of Speech Therapy assessments found three records (OD, WHG, MH) in compliance and three records (MLB, AKK, JP) not in compliance. A review of the records of eight individuals (CT, MJG, MMV, NYC, PC, RC, SSM and YMW) to assess compliance with timeliness of Occupational Therapy assessments found three records (MJG, RC, SSM)in compliance and five records (YMW, PC, NYC, CT, MMV) not in compliance. A review of the records of four individuals (DB, DS, RLE and RR) to assess compliance with timeliness of Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found one record (RLE) in compliance and three records (DS, RR, and DB) not in compliance. **Compliance:** Partial.

		Current recommendation: Ensure that each individual served receives Integrated Rehabilitation Therapy assessments (upon admission) and focused Rehabilitation Therapy assessments (as clinically indicated) that are completed in accordance with facility standards for timeliness.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement D.4 monitoring tool(s) for admission and focused assessments that report data on EP cells pertaining to all Rehabilitation Therapy assessments (Integrated admission and Focused) according to DMH format/standards. **Findings:** The following audit tools were developed and were implemented in April 2008: MH-C 9044b DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Form Instructions; MH-C 9044c DMH Occupational Therapy Assessment Monitoring Form Instructions; MH-C 9044d DMH Physical Therapy Assessment Monitoring Form Instructions; and MH-C 9044e DMH Speech-Language Pathology Assessment Monitoring Form Instructions. The MH-C 9044f DMH Vocational Rehabilitation Assessment Monitoring Form and Instructions were implemented in May 2008. Data was provided for May-October 2008 for all monitoring tools. **Recommendation 2, June 2008:** Ensure that auditors have received training on monitoring tools and that inter-rater agreement has been established for Integrated Assessment-Rehabilitation Services section and focused assessments monitoring prior to implementation.

Findings:
See D.4.c. for findings regarding training.

An inter-rater agreement process was performed by a standard rater against the other IA-RTS raters and agreement was calculated to be 89% by the Standards Compliance department. The focused assessments were audited by only one auditor, and therefore no inter-rater agreement data were available.

Recommendation 3, June 2008:
Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.

Findings:
Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 99% of Integrated Rehabilitation Therapy assessments due each month for the review period of May-October 2008 (total of 591 out of 596). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	92%
2.a	*Identifying information is fully documented*	99%
2.b	*Previous rehabilitation therapy assessments, POST evaluations, vocational evaluations, WRP's and other salient medical records (e.g., 24-hour admission assessments), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented*	99%
2.c	*Structured assessment activities and pertinent*	100%

	information related to setting/time are listed	
2.d	*Leisure and enrichment profile items are completed*	100%
2.e	*Functional observation items are completed for [all pertinent sections]*	93%

The overall mean compliance rate for item 2 was 92% in the current review period, compared to 71% in the previous review period.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 63% of Vocational Rehabilitation assessments due each month for the review period of May-October 2008 (total of 20 out of 32). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	84%
2.b	*Previous Vocational evaluations, rehabilitation therapy assessments, POST evaluations, WRP plans and other salient medical records (e.g. 24-hour admission assessment), interview of individual, chart review, observation of structured activities used in the assessment process, and consultations are reviewed and documented.*	47%
2.c	*Educational background items are completed.*	100%
2.d	*Employment history items are completed.*	84%
2.e	*Personal grooming and appearance items are completed.*	95%
2.f	*All physical functioning items are completed and specific functional measurements are documented if appropriate.*	100%

2.g	*All standardized assessments, as indicated.*	0%

No comparable data were available from the previous review period. The facility plan of correction to improve compliance is to increase staff to complete VRAT assessments as well as mentor all assessors to include specific applicable evaluations and ensure the identifying information is complete.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 88% of Occupational Therapy assessments due each month for the review period of May-October 2008 (total of 36 out of 41). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	94%
2.b	*Onset date completed*	100%
2.c	*Previous pertinent clinical assessments, WRPs and other salient medical records, interview of individual, chart review, observation, and consultations are reviewed and documented.*	100%
2.d	*Prior level of functioning completed including equipment owned*	97%
2.e	*Pertinent medical history completed, including precautions.*	100%
2.f	*Current functional abilities are addressed including:*	100%

No comparable data were available from the previous review period regarding mean compliance as the assessment was implemented in April 2008.

The facility's plan of correction to improve compliance is to provide staff mentoring over the next reporting period.

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 7% of Physical Therapy assessments due each month for the review period of May-October 2008 (total of 10 out of 136). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	80%
2.b	*Diagnosis*	100%
2.c	*Functional PT diagnosis*	100%
2.d	*Onset date*	100%
2.e	*Age*	100%
2.f	*Chief complaint/mechanism of injury*	100%
2.g	*Past Medical History*	100%
2.h	*Prior level of function*	100%
2.i	*Special precautions*	100%
2.j	*Orientation*	90%

No comparable data regarding mean compliance were available from the previous review period, as the assessment was implemented in April 2008.

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Compliance rate in last month of period		
2.	100%	0%
2.a	100%	100%
2.j	100%	0%

The facility's plan of correction to improve compliance is to provide staff mentoring over the next reporting period.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 90% of Speech Therapy assessments due each month for the review period of May-October 2008 (total of 30 out of 32). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	
2.a	*Identifying information is fully documented*	97%
2.b	*Previous Speech and Language Pathology assessments, POST evaluations, WRP's and other salient medical records, interview of individual, chart review, observation, and consultations are reviewed and documented.*	63%
2.c	*Relevant background information includes developmental, family history, education, and history of substance abuse*	100%
2.d	*Evaluation procedures/processes are written and described*	100%
2.e	*Results are written and statements made about the validity of the results and the individual's*	100%

	performance is noted on each measure.	
2.f	*All sections are addressed as appropriate*	100%

No comparable data regarding mean compliance were available from the previous review period, as the assessment was implemented in April 2008.

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Compliance rate in last month of period		
2.b	75%	80%

The facility's plan of correction to improve compliance is to provide staff mentoring over the next reporting period.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of May-October 2008 (total of 7). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

2.	*Is accurate and comprehensive as to the individuals functional abilities;*	43%
2.a	*Identifying information is fully documented*	71%
2.b	*Previous POST evaluations, Vocational evaluations, WRPs plans and other salient medical records, interview of individual, chart review, observation, and consultations are reviewed and documented.*	86%

2.c	*Pertinent medical history completed, including precautions*	100%
2.d	*Prior level of functioning in all areas is addressed, including adaptive equipment*	100%
2.e	*Current functional abilities are addressed, as indicated*	43%

No comparable data regarding mean compliance were available from the previous review period, as the assessment was implemented in April 2008.

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
	0%	43%
Compliance rate in last month of period		
2.a	100%	67%
2.b	100%	100%
2.e	0%	67%

The facility's plan of correction to improve compliance is to provide staff mentoring over the next reporting period.

Other findings:
A review of the records of seventeen individuals (BLG, CHF, DDP, EF, EJM, EWM, HAB, JAH, LMG, MAV, MG, MSF, RE, RF, RM, SGM and SR) to assess compliance with D.4.b.i for D.4 IA-RTS assessments found that records for all individuals but one (EF) were in substantial compliance.

		A review of the records of eight individuals (DNW, FLL, JTJ, LMB, MDB, MLW, RAD and VDM) to assess compliance with D.4.b.i in type D.4 Vocational Rehabilitation focused assessments found all eight records in partial compliance. An identified trend that the facility should focus on in order to improve compliance is that all Vocational Rehabilitation assessments are not consistently comprehensive. A review of the records of six individuals (AKK, JP, MH, MLB, OD and WHG) to assess compliance with D.4.b.i in type D.4 Speech Therapy focused assessments found five records (OD, WHG, MH, JP) in substantial compliance, and two records (MLB, AKK) in partial compliance. A review of the records of eight individuals (CT, MJG, MMV, NYC, PC, RC, SSM and YMW) to assess compliance with D.4.b.i in type D.4 Occupational Therapy focused assessments found all eight records in substantial compliance. A review of the records of five individuals (BKP, DFV, DMZ, JH and KCO) to assess compliance with D.4.b.i in type D.4 Physical Therapy focused assessments found three records (BKP, JH, DMZ) in substantial compliance, and two records (DFV, KCO) in partial compliance. A review of the records of four individuals (DB, DS, RLE and RR) to assess compliance with D.4.b.i in type D.4 Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found that all four records in substantial compliance. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities.

		2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.i criteria.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 99% of Integrated Rehabilitation Therapy assessments due each month for the review period of May-October 2008 (total of 591 out of 596). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

3.	*Identifies the individual's current functional status, and*	95%
3.a	*The functional status is described for Physical Functioning*	97%
3.b	*The functional status is described for Social Functioning*	97%
3.c	*The functional status is described for Life Skills*	99%
4.	*The skills and supports needed to facilitate transfer to the next level of care; and*	100%
4.a	*A description of the skills and supports necessary to live in the setting in which she/he will be placed, and*	100%
4.b	*A discussion of possible progression/steps towards this level of independence.*	100%

The mean compliance rates for items 3 and 4 in the current review period were 95% and 100% respectively, compared to 92% and 96% in the previous review period.

Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 63% of Vocational Rehabilitation assessments due each month for the review period of May-October 2008 (total of 20 out of 32). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

3.	*Identifies the individual's current functional status, and*	32%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	37%

No comparable data were available from the previous review period. The facility attributed low compliance to the failure to provide comprehensive written responses to these questions per the instructions. The facility plan of correction to improve compliance is to increase staff to complete VRAT assessments and mentor staff individually to include the information necessary to ensure comprehensive written responses.

Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 88% of Occupational Therapy assessments due each month for the review period of May-October 2008 (total of 36 out of 41). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	89%

No comparable data were available from the previous review period regarding mean compliance as the assessment was implemented in April 2008.

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Compliance rate in last month of period		
3.	0%	100%
4.	0%	100%

Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 7% of Physical Therapy assessments due each month for the review period of May-October 2008 (total of 10 out of 136). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

3.	*Identifies the individual's current functional status, and*	90%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	90%

No comparable data were available from the previous review period.

Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 90% of Speech Therapy assessments due each month for the review period of May-October 2008 (total of 30 out of 32). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

No comparable data were available from the previous review period regarding mean compliance as the assessment was implemented in April 2008.

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Compliance rate in last month of period		
3.	50%	100%
4.	75%	100%

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of May-October 2008 (total of 7). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

3.	*Identifies the individual's current functional status, and*	100%
4.	*The skills and supports needed to facilitate transfer to the next level of care*	100%

No comparable data were available from the previous review.

Other findings:
A review of the records of 17 individuals (BLG, CHF, DDP, EF, EJM, EWM, HAB, JAH, LMG, MAV, MG, MSF, RE, RF, RM, SGM and SR) to assess compliance with D.4.b.ii in D.4 IA-RTS assessments found all 17 records in substantial compliance.

A review of the records of 8 individuals (DNW, FLL, JTJ, LMB, MDB, MLW, RAD and VDM) to assess compliance with D.4.b.ii in type D.4 Vocational Rehabilitation focused assessments found three records to be in substantial compliance (FLL, RAD, VDM), one record in partial compliance (LMB), and four records (MDB, JTJ, MLW, DNW) not in compliance. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Assessments do not consistently provide thorough analysis of functional status.
2. Assessments do not consistently discuss skills and supports needed to facilitate transfer to the next level of care that are in line with the individual's needs.

A review of the records of eight individuals (CT, MJG, MMV, NYC, PC, RC, SSM and YMW) to assess compliance with D.4.b.ii in type D.4 Occupational Therapy focused assessments found six records in substantial compliance (PC, NYC, CT, RC, MMV, SSM), one record in partial compliance (MJG), and one record not in compliance (YMW).

		A review of the records of five individuals (BKP, DFV, DMZ, JH and KCO) to assess compliance with D.4.b.ii in type D.4 Physical Therapy focused assessments found all five records in substantial compliance. A review of the records of six individuals (AKK, JP, MH, MLB, OD and WHG) to assess compliance with D.4.b.ii in type D.4 Speech Therapy focused assessments found four records in substantial compliance (OD, WHG, MH, and JP) and two records not in compliance (MLB, AKK). A review of the records of four individuals (DB, DS, RLE and RR) to assess compliance with D.4.b.ii in type D.4 Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found all four records in substantial compliance. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.ii criteria.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths and motivation for engaging in wellness activities. **Findings:** Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 99% of Integrated Rehabilitation Therapy

assessments due each month for the review period of May-October 2008 (total of 591 out of 596). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

5.	*Identifies the individual's life goals,*	98%
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	98%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	100%
6.	*Strengths, and:*	95%
6.a	*The individual's strengths for engaging in wellness activities are identified*	96%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	98%
7.	*Motivation for engaging in wellness activities*	98%
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	98%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	98%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	99%

Using the DMH Vocational Rehabilitation Focused Assessment Tool,

PSH assessed its compliance with D.4.b.iii based on an average sample of 63% of Vocational Rehabilitation assessments due each month for the review period of May-October 2008 (total of 20 out of 32). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified, including at least one of the following: dreams, hopes, aspirations, desire for future education, desire for occupational skills, or other explicit relevant statements.*	100%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such.*	100%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	53%
6.b	*Strengths may include both direct quotes from the individuals as well as the therapist's assessment of the individual's strengths. If quotes are not used as a result of the individual's non-verbal status it is stated as such.*	58%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	26%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	16%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	68%

No comparable data were available from the previous review period. The facility's plan of correction to improve compliance is to provide training and mentoring to staff on specific audit results.

Using the DMH Occupational Therapy Focused Assessment Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 88% of Occupational Therapy assessments due each month for the review period of May-October 2008 (total of 36 out of 41). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	100%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	100%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	97%
6.b	*Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength*	91%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	97%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	100%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	97%

No comparable data were available from the previous review.

Using the DMH Physical Therapy Focused Assessment Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 7% of Physical Therapy assessments due each month for the review period of May-October 2008 (total of 10 out of 136). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	80%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	70%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	70%
6.b	*Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength*	20%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	70%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	60%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	80%

No comparable data were available from the previous review period

regarding mean compliance as the assessment was implemented in April 2008.

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Compliance rate in last month of period		
5.	100%	100%
5.a	100%	100%
5.b	100%	100%
6.	0%	100%
6.a	0%	100%
6.b	0%	100%
7.	0%	100%
7.a	0%	100%
7.b	0%	100%
7.c	0%	100%

Using the DMH Speech Therapy Focused Assessment Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 90% of Speech Therapy assessments due each month for the review period of May-October 2008 (total of 30 out of 32). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	97%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	100%

6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	70%
6.b	*Strengths may include both direct quotes from the individual as well as the therapist's assessment of the individual's strength*	60%
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	47%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	87%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	70%

No comparable data were available from the previous review period regarding mean compliance as the assessment was implemented in April 2008.

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Compliance rate in last month of period		
5.	75%	100%
6.	0%	60%
6.a	75%	80%
6.b	0%	60%
7.	0%	40%

	Previous period	Current period
Compliance rate in last month of period		
7.a	0%	40%
7.b	0%	100%
7.c	25%	40%

The facility attributed low compliance with item 6 to the therapist often failing to include input on the individual's strengths, and low compliance with item 7 to the therapist often not including what motivates the individual in general or the therapist's assessment of what will motivate the individual in treatment. The facility plans to mentor the clinician to improve performance to attain substantial compliance in both areas.

Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Tool, PSH assessed its compliance with D.4.b.iii based on an average sample of 100% of Comprehensive Physical Rehabilitation Therapy assessments due each month for the review period of May-October 2008 (total of 7). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

5.	*Identifies the individual's life goals,*	
5.a	*The individual's life goals are identified*	100%
5.b	*Direct quotes in the individual's own words are used or if quotes are not used as a result of individual's non-verbal status it is stated as such*	100%
6.	*Strengths, and:*	
6.a	*The individual's strengths for engaging in wellness activities are identified*	100%
6.b	*Strengths may include both direct quotes from*	71%

	the individual as well as the therapist's assessment of the individual's strength	
7.	*Motivation for engaging in wellness activities*	
7.a	*Individual's motivation for engaging in wellness activities are identified with individual's response to the following [required] questions*	100%
7.b	*The individual's current level of motivation has been identified by considering the individual's stage of change, and;*	100%
7.c	*Motivation may include both direct quotes from the individual as well as the therapist's assessment of the individual's motivation*	100%

No comparable data were available from the previous review period regarding mean compliance as the assessment was implemented in April 2008.

Comparative data showed decline in compliance with item 6 since the last review as follows:

	Previous period	Current period
Compliance rate in last month of period		
5.	100%	100%
6.	100%	71%
7.	100%	100%

Other findings:
A review of the records of 17 individuals (BLG, CHF, DDP, EF, EJM, EWM, HAB, JAH, LMG, MAV, MG, MSF, RE, RF, RM, SGM and SR) to assess compliance with D.4.b.iii in D.4 IA-RTS assessments found 16 records in substantial compliance and one record in partial compliance (SGM).

		A review of the records of eight individuals (DNW, FLL, JTJ, LMB, MDB, MLW, RAD and VDM) to assess compliance with D.4.b.iii in type D.4 Vocational Rehabilitation focused assessments found one record in substantial compliance (VDM), five records in partial compliance (FLL, LMB, RAD, MDB, MLW), and two records not in compliance (JTJ, DNW). Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Assessments do not consistently provide thorough analysis of individual life goals for engaging in wellness activities. 2. Assessments do not consistently provide thorough analysis of individual strengths for engaging in wellness activities. 3. Assessments do not consistently provide thorough analysis of individual motivation for engaging in wellness activities. A review of the records of eight individuals (CT, MJG, MMV, NYC, PC, RC, SSM and YMW) to assess compliance with D.4.b.iii in type D.4 Occupational Therapy focused assessments found six records in substantial compliance (PC, NYC, CT, MJG, MMV, SSM), one record in partial compliance (RC), and one record not in compliance (YMW). A review of the records of five individuals (BKP, DFV, DMZ, JH and KCO) to assess compliance with D.4.b.iii in type D.4 Physical Therapy focused assessments found three records in substantial compliance (KCO, JH, DMZ) and two records in partial compliance (BKP, DFV). A review of the records of six individuals (AKK, JP, MH, MLB, OD and WHG) to assess compliance with D.4.b.iii in type D.4 Speech Therapy focused assessments found five records in substantial compliance and one record in partial compliance (MH).

		A review of the records of four individuals (DB, DS, RLE and RR) to assess compliance with D.4.b.iii in type D.4 Comprehensive Integrated Physical Rehabilitation Therapy focused assessments found all four records in substantial compliance. **Current recommendations**: 1. Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities. 2. Implement plans of correction based on review of audit data to improve compliance with D.4.b.iii criteria.
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that staff who are performing assessments (admission and focused) have been trained to competency. **Findings:** According to facility report, three out of 15 new Rehabilitation staff therapists received training to competency on the training materials for the Integrated Assessment: Rehabilitation Therapy Section on 5/21/08, 6/20/08, and 9/26/08. The training was verified by review of raw data from training rosters and training post-tests. All four Vocational Rehabilitation staff members who are performing Vocational Rehabilitation assessments received competency-based training on the Vocational Rehabilitation Assessment on 10/29/08 and were trained to competency on training materials. This training was verified by review of raw data from training rosters and training post-tests. The Physical Therapist who is performing Physical Therapy assessments

		received competency-based training on the Physical Therapy focused assessment on 5/9/08 and was trained to competency on training materials. This training was verified by review of raw data from training rosters and training post-tests. Both new Occupational Therapy staff members who are performing Occupational Therapy assessments received competency-based training on the Occupational Therapy focused assessment on 6/18/08 and were trained to competency on training materials. This training was verified by review of raw data from training rosters and training post-tests. All six POST team members who are performing Comprehensive Integrated Physical Rehabilitation Therapy assessments received training to competency on training materials related to the Comprehensive Integrated Physical Rehabilitation Therapy focused assessment on 5/2/08, 6/19/08, 6/27/08, and 10/23/08. This training was verified by review of raw data from training rosters and training post-tests. **Recommendation 2, June 2008:** Develop and implement a system to analyze audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments) and provide feedback to staff regarding performance improvement and recommendations for training/CEU courses based on these findings and track CEU courses attended by Rehabilitation Therapy staff. **Findings:** This recommendation has not been addressed. **Recommendation 3, June 2008:** Develop and implement a system to analyze IA-RTS audit data and

		provide group trend-based training. **Findings:** The facility reported that the master-rater for the IA-RTS analyzes the Plato data results for trending. The master-rater then meets with the RIAT members to offer performance improvement-related training based on any negative trending. The master-rater trains all new Rehabilitation Therapists, as well as any existing service members in need of re-training or mentoring based on audit results. All therapists who attend didactic training must also attend a session in the assessment clinic, where they complete an IA-RTS with assistance from the clinic staff. These IA-RTS are e-mailed to the master-rater who scores them for compliance and offers feedback. All staff who do not achieve compliance with the audit tool will continue to complete IA-RTSs in the clinic until compliance is met. **Compliance:** Partial. **Current recommendations**: 1. Ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible. 2. Develop and implement a system to recommend training CEU courses based on findings of audit data, and track CEU courses attended by Rehabilitation Therapy staff.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that all individuals admitted to PSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months.

		Findings: According to facility report, 535 out of 680 type D.4.d assessments were completed during the May-October 2008 review period. **Other findings:** A review of the records of twelve individuals (DRL, EW, JBM, KAM, MLM, RDP, RJS, RMM, RW, WDW, YMH and YTP) who were reported to have received type D.4.d IA-RTS assessments found that all records had evidence of completed assessments. Six records (EW, JBM, RJS, RMM, RW and YMH) were in substantial compliance with D.4.d and six records (DRL, KAM, MLM, RDP, WDW and YTP) were in partial compliance with D.4.d in regards to assessment quality. **Compliance:** Partial. **Current recommendation**: Ensure that all individuals admitted to PSH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next six months.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Brian Starck-Riley, Assistant Director of Nutrition Services 2. Diana Tran, Assistant Director of Nutrition Services 3. Dolores Otto-Moreno, Assistant Director of Nutrition Services 4. Grace Ferris, Assistant Director of Nutrition Services 5. Jeanie Kim, Assistant Director of Nutrition Services 6. Kitchie Miana, Assistant Director of Nutrition Services 7. Tai Kim, Director of Nutrition Services Reviewed: 1. Nutrition Care Monitoring audit data for May-October 2008 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from May-October 2008 for each assessment type 3. Records for the following two individuals with type D.5.a assessments from May-October 2008: ATL and MN 4. Records for the following six individuals with type D.5.d assessments from May-October 2008: BM, BRC, DET, HM, KLA and MLJ 5. Records for the following five individuals with type D.5.e assessments from May-October 2008: AMO, CHF, LES, RDS and VGR 6. Records for the following seven individuals with type D.5.f assessments from May-October 2008: AG, HMM, JAH, JMP, JRS, MSR and SHW 7. Records for the following 13 individuals with type D.5.g assessments from May-October 2008: BRT, DA, EWM, JLH, JME, KLD, MJC, MS, ND, PLM, SMG, TDW and YMV 8. Records for the following 11 individuals with type D.5.i assessments from May-October 2008: BDS, BLM, CAZ, JAG, KLA, RA, RCH,

		RWT, SR, SW and VQ 9. Records for the following 10 individuals with type D.5.j.i assessments from May-October 2008: BN, DAR, DLD, ELF, GWA, JPW, MS, RAG, SH and SMC 10. Records for the following 13 individuals with type D.5.j.ii assessments from May-October 2008: ANA, BEH, BMS, CMJ, CY, DAD, GCD, JGR, JLC, JP, KS, MB and TM
D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.a Assessments due each month for the review period of May-October 2008 (total of two). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	50%
4.	*Estimated daily needs for nutrients specified are appropriate*	50%
5.	*Assessment utilizes findings from subjective and objective data*	100%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	100%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers*	100%

	identified	
9.	*Progress is monitored, measured, and evaluated*	n/a
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	100%
11.	*Recommendations are appropriate and complete*	100%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	n/a
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Data comparison between current and previous review period was not provided.

The facility attributed poor compliance with items 3 and 4 to a small sample size. The facility's plan to improve compliance is to provide feedback and training based on audit findings to Dietitians as a group during monthly meetings, and to provide feedback and training based on audit findings and annual performance evaluations on an individual basis. In addition, Dietitians are provided with monthly audit reports and data sheets to track their progress towards compliance with Nutrition Care assessments.

Other findings:
A review of the records of two individuals (ATL and MN) to assess compliance with Nutrition type D.5.a assessment criteria found one record (ATL) in substantial compliance and one record (MN) in partial compliance.

		Compliance: Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.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.
D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. PSH does not have a skilled nursing facility unit.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.d Assessments due each month for the review period of May-October 2008 (total of 68). The following outlines the indicators with corresponding mean compliance rates for May-October 2008: 1. *Assessment is completed on time per policy* 76% 2. *All required subjective concerns are addressed* 96% 3. *All pertinent objective nutrition information is accurately addressed* 87% 4. *Estimated daily needs for nutrients specified are* 88%

	appropriate	
5.	*Assessment utilizes findings from subjective and objective data*	90%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	93%
7.	*Nutrition education is documented*	100%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	99%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	93%
11.	*Recommendations are appropriate and complete*	89%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	96%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	99%
18.	*Each page of the assessment is signed*	99%

Data comparison between current and previous review period was not provided.

The facility attributed the less than substantial compliance with item 1 to late notification and non-notification. The facility's plan to improve compliance is the same as that outlined in D.5.a.

		Other findings: A review of the records of six individuals (BM, BRC, DET, HM, KLA and MLJ) to assess compliance with Nutrition type D.5.d assessment criteria found five records (BM, BRC, DET, KLA and MLJ) in substantial compliance and one record (HM) in partial compliance. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.e Assessments due each month for the review period of May-October 2008 (total of 36). The following outlines the indicators with corresponding mean compliance rates for May-October 2008: 1. *Assessment is completed on time per policy* 85% 2. *All required subjective concerns are addressed* 100% 3. *All pertinent objective nutrition information is accurately addressed* 85% 4. *Estimated daily needs for nutrients specified are appropriate* 96% 5. *Assessment utilizes findings from subjective and objective data* 96% 6. *Nutrition diagnosis is correctly formulated,* 88%

	prioritized and validated	
7.	*Nutrition education is documented*	96%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	96%
11.	*Recommendations are appropriate and complete*	91%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	100%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	92%

Data comparison between current and previous review period was not provided.

The facility attributed the less than substantial compliance with item 1 to late notification and non-notification regarding therapeutic diets. The facility's plan to improve compliance is the same as that outlined in D.5.a.

Other findings:
A review of the records of five individuals (AMO, CHF, LES, RDS and VGR) to assess compliance with Nutrition type D.5.e assessment criteria found four records (AMO, CHF, RDS and VGR) in substantial compliance and one record (LES) in partial compliance.

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

Current recommendation:
Continue current efforts to achieve compliance.</td></tr>
<tr><td>D.5.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 recommendation:

Recommendation, June 2008:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of Nutrition Type D.5.f Assessments for each month for the review period of May-October 2008 (total of 59). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:
<table>
<tr><td>1.</td><td>Assessment is completed on time per policy</td><td>86%</td></tr>
<tr><td>2.</td><td>All required subjective concerns are addressed</td><td>97%</td></tr>
<tr><td>3.</td><td>All pertinent objective nutrition information is accurately addressed</td><td>88%</td></tr>
<tr><td>4.</td><td>Estimated daily needs for nutrients specified are appropriate</td><td>90%</td></tr>
<tr><td>5.</td><td>Assessment utilizes findings from subjective and objective data</td><td>93%</td></tr>
<tr><td>6.</td><td>Nutrition diagnosis is correctly formulated, prioritized and validated</td><td>100%</td></tr>
<tr><td>7.</td><td>Nutrition education is documented</td><td>100%</td></tr>
<tr><td>8.</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>100%</td></tr>
</table></td></tr>
</table>

9.	*Progress is monitored, measured, and evaluated*	100%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	90%
11.	*Recommendations are appropriate and complete*	96%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	93%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	98%
18.	*Each page of the assessment is signed*	98%

Data comparison between current and previous review period was not provided.

The facility attributed the less than substantial compliance with item 1 to late notification and non-notification. The facility's plan to improve compliance is the same as that outlined in D.5.a.

Other findings:
A review of the records of seven individuals (AG, HMM, JAH, JMP, JRS, MSR and SHW) to assess compliance with Nutrition type D.5.f assessment criteria found four records (AG, HMM, MSR and SHW) in substantial compliance and three records (JAH, JMP and JRS) in partial compliance. An identified trend that the facility should focus on in order to improve compliance is that nutrition diagnoses are not consistently correctly formulated, prioritized and validated.

Compliance:
Partial.

		Current recommendation: Continue current efforts to achieve compliance.
D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 20% of Nutrition Type D.5.g Assessments due each month for the review period of May-October 2008 (78 out of 388). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Assessment is completed on time per policy*	100%
2.	*All required subjective concerns are addressed*	97%
3.	*All pertinent objective nutrition information is accurately addressed*	97%
4.	*Estimated daily needs for nutrients specified are appropriate*	97%
5.	*Assessment utilizes findings from subjective and objective data*	97%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	97%
7.	*Nutrition education is documented*	99%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	n/a
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	94%

11.	*Recommendations are appropriate and complete*	90%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	91%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	n/a
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	97%
16.	*Assessment is concise*	100%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	96%

Data comparison between current and previous review period was not provided.

Other findings:
A review of the records of 13 individuals (BRT, DA, EWM, JLH, JME, KLD, MJC, MS, ND, PLM, SMG, TDW and YMV) to assess compliance with Nutrition type D.5.g assessment criteria found eight records (BRT, DA, EWM, JLH, KLD, ND, PLM and TDW) in substantial compliance and five records (JME, MJC, MS, SMG and YMV) in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.g assessments include:

1. Nutrition diagnoses are not consistently correctly formulated, prioritized and validated.
2. Nutrition objectives are not consistently specific, behavioral, observable and measurable.

Compliance:
Partial.

		Current recommendation: Continue current efforts to achieve compliance.
D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 26% of all Nutrition Type D.5.h Assessments due each month for the review period of May-October 2008 (609 out of 2337) to assess compliance with D.5.h. The facility found that 94% (weighted mean) of Nutrition admission assessments audited had evidence of a correctly assigned NST level. **Other findings:** A review of records of 66 individuals (AG, AMO, ANA, ATL, BDS, BEH, BLM, BM, BMS, BN, BRC, BRT, CAZ, CHF, CMJ, CY, DA, DAD, DAR, DET, DLD, ELF, EWM, GCD, GWA, HM, HMM, JAG, JAH, JGR, JLC, JLH, JME, JMP, JP, JPW, JRS, KLA [two assessments reviewed], KLD, KS, LES, MB, MJC, MLJ, MN, MS, MS-2, MSR, ND, PLM, RA, RAG, RCH, RDS, RWT, SH, SHW, SMC, SMG, SR, SW, TDW, TM, VGR, VQ and YLH) to assess compliance with D.5.h. found 64 records in compliance and three records (JPW, JRS and MS) not in compliance. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.i Assessments due each month for the review period of May-October 2008 (total of 207 out of 1009). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Assessment is completed on time per policy*	35%
2.	*All required subjective concerns are addressed*	99%
3.	*All pertinent objective nutrition information is accurately addressed*	86%
4.	*Estimated daily needs for nutrients specified are appropriate*	87%
5.	*Assessment utilizes findings from subjective and objective data*	96%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	97%
7.	*Nutrition education is documented*	91%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	97%
9.	*Progress is monitored, measured, and evaluated*	97%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	93%
11.	*Recommendations are appropriate and complete*	90%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	96%
13.	*Food/fluid consistency is addressed when*	92%

	actual/potential aspiration/dysphagia is present	
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	100%
16.	*Assessment is concise*	99%
17.	*Assessment is legible*	99%
18.	*Each page of the assessment is signed*	100%

Data comparison between current and previous review period was not provided.

The facility attributed poor compliance with item 1 to Dietitian vacancies and an average caseload of 150 individuals for each clinical Dietitian. The facility's plan to improve compliance is the same as that outlined in D.5.a.

Other findings:
The facility reported that as of the week of review, 684 Nutrition type D.5.i. Assessments due during the review period had not been completed. This is attributed to inadequate staffing of Clinical Dietitians.

A review of the records of eleven individuals (BDS, BLM, CAZ, JAG, KLA, RA, RCH, RWT, SR, SW and VQ) to assess compliance with Nutrition type D.5.i assessment criteria found six records (CAZ, JAG, KLA, RCH, RWT and SR) in substantial compliance and five records (BDS, BLM, RA, SW and VQ) in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.i assessments include:

1. Nutrition diagnoses are not consistently correctly formulated, prioritized and validated.
2. Nutrition recommendations are not consistently specific, complete,

		and aligned with diagnosis and objectives. **Compliance:** Partial. **Current recommendation:** Continue current efforts to achieve compliance.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 23% of Nutrition Type D.5.j.i Assessments due each month for the review period of May-October 2008 (total of 59 out of 259). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Assessment is completed on time per policy*	78%
2.	*All required subjective concerns are addressed*	98%
3.	*All pertinent objective nutrition information is accurately addressed*	77%
4.	*Estimated daily needs for nutrients specified are appropriate*	85%
5.	*Assessment utilizes findings from subjective and objective data*	93%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	91%
7.	*Nutrition education is documented*	96%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers*	100%

	identified	
9.	*Progress is monitored, measured, and evaluated*	93%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	91%
11.	*Recommendations are appropriate and complete*	80%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	98%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	100%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	98%
16.	*Assessment is concise*	98%
17.	*Assessment is legible*	95%
18.	*Each page of the assessment is signed*	98%

The facility reported that compliance with item 1 increased from 71% in the previous period to 78% in the current reporting period. The facility attributed less than substantial compliance with item 1 to Dietitian vacancies and an average caseload of 150 individuals for each clinical Dietitian. The facility's plan to improve compliance is the same as that outlined in D.5.a.

Recommendation 2, June 2008:
Ensure that referrals for type D.5.j.i assessments are sent and answered in accordance with facility procedures.

Findings:
The facility reported that a process has been implemented by which all callers requesting consultations by phone are instructed to complete a written consultation to be sent through inter-office mail. This process enables the Nutrition department to maintain a written record of the all Nutrition type D.5.j.i consultation assessments.

		Other findings: A review of the records of ten individuals (BN, DAR, DLD, ELF, GWA, JPW, MS, RAG, SH and SMC) to assess compliance with Nutrition type D.5.j.i assessment criteria found five records (BN, DAR, DLD, ELF and RAG) in substantial compliance and five records (GWA, JPW, MS, SH and SMC) in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.j.i assessments include: 1. Objective findings are not consistently comprehensively documented. 2. Nutrition objectives are not consistently specific, behavioral, observable and measurable. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 21% of Nutrition Type D.5.j.ii Assessments due each month for the review period of May-October 2008 (total of 110 out of 526). The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

1.	*Assessment is completed on time per policy*	32%
2.	*All required subjective concerns are addressed*	100%
3.	*All pertinent objective nutrition information is accurately addressed*	89%
4.	*Estimated daily needs for nutrients specified are appropriate*	100%
5.	*Assessment utilizes findings from subjective and objective data*	95%
6.	*Nutrition diagnosis is correctly formulated, prioritized and validated*	97%
7.	*Nutrition education is documented*	94%
8.	*Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified*	100%
9.	*Progress is monitored, measured, and evaluated*	94%
10.	*Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable*	97%
11.	*Recommendations are appropriate and complete*	91%
12.	*NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment*	89%
13.	*Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present*	80%
14.	*Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support*	n/a
15.	*Assessment utilizes approved abbreviations*	97%
16.	*Assessment is concise*	97%
17.	*Assessment is legible*	100%
18.	*Each page of the assessment is signed*	100%

Data comparison between current and previous review period was not provided.

		The facility attributed poor compliance with item 1 to Dietitian vacancies and an average caseload of 150 individuals for each clinical Dietitian, as well as to the prioritizing of higher acuity assessments. The facility's plan to improve compliance is the same as that outlined in D.5.a. **Other findings:** The facility reported that as of the week of review, 319 Nutrition type D.5.j.ii Assessments due during the review period had not been completed. This is attributed to inadequate staffing of Clinical Dietitians. A review of the records of thirteen individuals (ANA, BEH, BMS, CMJ, CY, DAD, GCD, JGR, JLC, JP, KS, MB and TM) to assess compliance with Nutrition type D.5.j.ii assessment criteria found nine records (BMS, CMJ, CY, GCD, JLC, JP, KS, MB and TM) in substantial compliance and four records (ANA, BEH, DAD and JGR) in partial compliance. Identified areas of deficiency that the facility should focus on in order to improve compliance with Nutrition type D.5.j.ii assessments include: 1. Nutrition diagnoses are not consistently correctly formulated, prioritized and validated. 2. Objective findings are not consistently comprehensively documented. 3. Nutrition objectives are not consistently specific, behavioral, observable and measurable. **Compliance:** Partial. **Current recommendation:** Continue current efforts to achieve compliance.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that is consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Edward Williams, LCSW, Family Services Coordinator 2. Tiffany Rector, LCSW, (A) Supervising Social Worker 3. Veronica Kaufman, LCSW, Chief of Social Work Reviewed: 1. Charts of the following 14 charts: AB, AP, AR, AT, CT, DW, ER, ET, FB, HT, JL, MC, RJ and RM 2. DMH Integrated Assessment: Social Work Section 3. DMH Integrated Assessment: Social Work Section Instructions 4. DMH 30-Day Psychosocial Assessment 5. DMH 30-Day Psychosocial Assessment Instructions 6. Social Work Assessment Monitoring form Instruction Sheet 7. PSH Progress Report Data 8. Family Education Assessments Observed: 1. WRPC for JC (Program 1, Unit 5) 2. WRPC for KDK (Program VI, Unit 71) 3. WRPC for MB (Program VI, Unit 71)
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that the five-day and 30-day social history assessments are timely, accurate, and comprehensive. **Findings:** According to the Chief of Social Work, PSH has added new staff to complement the staffing needs of the assessment units. Senior

Supervising staff continues to provide training, mentoring, and feedback to eliminate barriers and improve compliance. Senior Supervising staff also reminds staff through emails on upcoming assessments and timelines. Audit data is regularly shared with SW staff with feedback on areas of deficit. Furthermore, PSH holds monthly incentive raffles for all admissions Social Workers achieving 100% compliance in their Integrated Assessments.

Using items 1-3 from the DMH Social History Assessments Monitoring Form, PSH assessed its compliance for the 5-Day SW Integrated Assessments based on an average sample of 93% of the Integrated Social Work Assessments due each month (May to October 2008). The table below is a summary of the data:

1.	*Is, to the extent reasonably possible, accurate*	76%
1.a	*Section 1: Identifying information is complete and accurate,*	95%
1.b	*Section 2: Sources of information includes the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed, and,*	83%
1.c	*The information in the assessment is factually correct and internally consistent.*	96%
2.	*Current, and*	83%
2.a	*Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient information in the assessment to indicate why these sources of information are not utilized.*	88%
2.b	*Includes behavioral observations since the time of admission*	92%

3.	*Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.*	88%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	78%	76%
2.	66%	83%
3.	85%	88%
Compliance rate in last month of period		
1.	63%	74%
1.a	96%	92%
1.b	70%	88%
1.c	95%	91%
2.	51%	88%
2.a	73%	93%
2.b	61%	93%
3.	82%	87%

This monitor reviewed 12 Social Work Integrated Assessments (AB, AP, AT, CT, DW, ER, FB, HT, JL, MC, RJ and RM). Nine of the Social Work Integrated Assessments in the charts (AP, AT, ER, FB, HT, JL, MC, RJ and RM) were current, accurate and comprehensive. The remaining two (AB and DW) were not current, accurate and/or comprehensive. One of them (CT) did not have the 5-Day Assessment.

PSH also used items 1-3 from the DMH Social History Assessments

Monitoring Form, PSH assessed its compliance for the 30-Day Social History Assessment based on an average sample of 27% of the Social History Assessments due each month (May to October 2008). The table below is a summary of the data:

1.	*Is, to the extent reasonably possible, accurate*	85%
1.a	*Section 1: Identifying Information is complete and accurate,*	95%
1.b	*Section 2: Sources of information includes the individual, collateral information sources and specific documents reviewed, or an explanation for not using these sources. Dates of contacts are listed as appropriate. Dates of source documents are listed, and,*	88%
1.c	*The information in the assessment is factually correct and internally consistent.*	97%
2.	*Current, and*	79%
2.a	*Assessment includes information from current interview, collateral sources, and source documents, or there is sufficient information in the assessment to indicate why these sources of information are not utilized.*	93%
2.b	*Includes behavioral observations since the time of admission*	83%
2.c	*Provides adequate information regarding the individual's current psychosocial functioning.*	84%
3.	*Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.*	88%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	81%	85%
2.	68%	79%
3.	80%	88%
Compliance rate in last month of period		
1.	80%	71%
1.a	100%	88%
1.b	80%	82%
1.c	100%	82%
2.	60%	71%
2.a	80%	88%
2.b	80%	76%
2.c	100%	76%
3.	100%	82%

This monitor reviewed 11 Social Work Social History Assessments (AB, AP, AT, CT, DW, ER, FB, HT, MC, RJ and RM). Seven of the Social Work Assessments in the charts (AP, AT, CT, DW, FB, HT and RM) were current, accurate, and comprehensive. The remaining four (AB, ER, MC and RJ) did not contain the 30-Day Social History Assessments.

As plan of correction: PSH will continue to reinforce staff achieving 100% compliance with awards and recognitions, and train those in need of improvement.

Compliance:
Partial.

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

Recommendations 1-3, June 2008:
• Ensure that social history assessments contain all relevant information.
• Ensure that social workers identify and address the inconsistencies in current assessments.
• Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.

Findings:
This monitor reviewed eight Social History assessments (AP, AT, DW, ER, FB, HT, MC and RM). All eight of them included all relevant information.

Findings:
Using items 4-6 from the DMH Social History Assessments Monitoring Form, PSH assessed its compliance for the 30-Day Psychosocial Assessments based on an average sample of 27% of the assessments due each month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>4.</td><td>Expressly identifies factual inconsistencies among sources.</td><td>91%</td></tr>
<tr><td>5.</td><td>Resolves or attempts to resolve inconsistencies.</td><td>88%</td></tr>
<tr><td>6.</td><td>Explains the rationale for the resolution offered.</td><td>86%</td></tr>
</table>

Comparative data showed mixed changes in compliance since the last review as follows:
</td></tr>
</table>

	Previous period	Current period
Mean compliance rate		
4.	85%	91%
5.	85%	88%
6.	83%	86%
Compliance rate in last month of period		
4.	92%	94%
5.	92%	88%
6.	92%	88%

This monitor reviewed eight charts (AP, AT, DW, ER, FB, HT, MC and RM). Factual inconsistencies were addressed and resolved in six of the assessments in the charts (AP, DW, ER, HT, MC and RM). The factual inconsistencies for FB were not resolved, and the documentation indicated that the individual would not consent for follow-up information. The inconsistencies for AT were identified but were not resolved and no rationale was given or a plan was identified.

As plan of correction: PSH will continue to reinforce staff achieving 100% compliance, and train those in need of improvement.

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.

D.6.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, June 2008:** 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:** Using item 7 from the DMH Social History Assessments Monitoring Form, PSH assessed its compliance for the 5-Day Social History Assessments based on an average sample of 93% of the assessments due each month (May to October 2008). The table below is a summary of the data:

7.	*Is included in the 7-day integrated assessment*	74%
7.a	*The assessment was completed within 5 calendar days of the individual's admission, and*	74%
7.b	*Filed in the medical record.*	90%

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	69%	74%
Compliance rate in last month of period		
7.	60%	77%
7.a	64%	77%
7.b	93%	94%

This monitor reviewed ten Social Work Integrated Assessments (AB, AP, DW, ER, FB, HT, JL, MC, RJ and RM). Nine of them were timely and were filed in the medical record, and one of them (MC) was not timely.

Recommendation 2, June 2008:
Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.

Findings:
Using item 8 from the DMH Social History Assessments Monitoring Form, PSH assessed its compliance for the 30-Day Psychosocial Assessments based on an average sample of 27% of the assessments due each month (May to October 2008). The table below is a summary of the data:

8.	*Fully documented by the 30th day of the individual's admission.*	63%
8.a	*Competed no earlier than the first work day after the 7-day WRPC and no later than the 30th calendar day after admission*	64%
8.b	*Filed in the medical record.*	75%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	62%	63%
Compliance rate in last month of period		
8.	56%	45%
8.a	68%	45%
8.b	70%	54%

This monitor reviewed ten charts (AB, AP, AT, CT, DW, ER, FB, HT, RJ and RM) containing the 30-Day Psychosocial Assessments. Seven of them (AP, AT, CT, DW, FB, HT and RM) were timely and were filed in the

		medical record. Three of them were not present in the charts (AB, ER and RJ). As plan of correction: PSH will continue to reinforce staff achieving 100% compliance, and train those in need of improvement. **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.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	**Current findings on previous recommendation:** **Recommendation, June 2008:** 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:** Using item 9 from the DMH Social History Assessments Monitoring Form, PSH assessed its compliance for the 30-Day Psychosocial Assessments based on an average sample of 19% of the assessments due each month (May to October 2008). The table below is a summary of the data: 9. *Social factors* 96% 9.a *Relatives and Significant Others includes names of significant others and nature of relationship, or states why this information is unavailable.* 100%

9.b	*Developmental History describes the individual's interpersonal relationships with others*	96%

There is no data for comparison as PSH did not audit this item for the previous review period.

Using item 10 from the DMH Social History Assessments Monitoring Form, PSH assessed its compliance for the 5-Day Social History Assessments based on an average sample of 93% of the assessments due each month (May to October 2008). The table below is a summary of the data:

10.	*Educational status*	97%
10.a	*Education includes educational level(s) completed by the individual and subject of any degrees or focus of any vocational training, or "Unknown" is checked.*	97%

In the previous review period, PSH reported compliance for items 10 and 10.a of 97% and 98% respectively.

This monitor reviewed 11 charts (AB, AP, AT, DW, ER, FB, HT, JL, MC, RJ and RM). Ten of the 5-Day Social History Assessments in the charts provided sufficient information on the individuals' educational and social status and discussed the impact on the individuals' Wellness and Recovery. One of them (AB) failed to satisfy this criteria.

Using item 10 from the DMH Social History Assessments Monitoring Form, PSH assessed its compliance for the 30-Day Psychosocial Assessments based on an average sample of 19% of the assessments due each month (May to October 2008). The table below is a summary of the data:

10.	*Educational status*	100%
10.a	*Education describes academic experiences including*	100%

	highest level of education completed, level of functioning in school, and special education needs.	

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.	49%	100%
Compliance rate in last month of period		
10.	21%	100%
10.a	29%	100%

This monitor reviewed seven charts (AP, AT, DW, ER, FB, HT and RM). All seven 30-Day Psychosocial assessments in the charts contained sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.

Compliance:
Substantial.

Current recommendation:
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: Ai-Li Arias, MD, Chair, Forensic Review Panel (FRP) Reviewed: 1. Charts of the following six individuals who were admitted under PC 1026: ALG, AM, DL, EC, MAS and RJS 2. Charts of the following six individuals who were admitted under PC 1370: AB, GAA, MDG, OG, PL and RJS 3. DMH Manual for the Preparation of PC 1026 and PC 1370 Court Reports 4. Minutes of the FRP (May to October 2008) 5. Examples of emails containing feedback from FRP to WRPTs 6. Court Report PC 1026 Audit Tool 7. Court Report PC 1026 summary data May to October 2008) 8. Court Report PC 1370 Audit Tool 9. Court Report PC 1370 summary data (May to October 2008)
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	**Compliance:** Substantial.
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e.,	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Continue current practice and ensure ongoing training of WRPTs

	instant offense);	regarding compliance with EP requirements. **Findings:** PSH provided formal PC 1026 Court Report Writing Training on October 1, 2008. The next scheduled training is planned for January 2009. **Recommendation 2, June 2008:** Continue to monitor this requirement based on a 100% sample. **Findings:** The facility has continued to monitor 100% of the PC 1026 reports using the standardized DMH tool. The following summarizes the number of reports reviewed by the FRP each month during this reporting period: Month: Reports reviewed May 2008: 71 June 2008: 64 July 2008: 53 August 2008: 35 September 2008: 29 October 2008: 72 The facility has maintained mean compliance rates greater than 90% for all the requirements of D.7.a since the last review. The rate was 98% for this requirement. The mean compliance rates for the requirements of D7.a.ii through D7.a.xi are reported in each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate.

		Other findings: This monitor reviewed the charts of six individuals who were admitted under PC 1026. The review found compliance in five charts (ALG, DL, EC, MAS and RJS) and partial compliance in one (AM). **Current recommendations**: 1. Ensure that all reports include a specific description of the nature of the individual's symptoms, their course and the setting within which they occur. 2. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements. 3. Continue to monitor this requirement based on a 50% sample.
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as above. **Findings:** PSH reported a mean compliance rate of 98% for this requirement. **Other findings:** This monitor found compliance in five charts (ALG, AM, EC, MAS and RJS) and partial compliance in one (DL). **Current recommendations**: 1. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements. 2. Continue to monitor this requirement based on a 50% sample.
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	**Current findings on previous recommendation:**

<table>
<tr>
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<td>Recommendation, June 2008:
Same as above.

Findings:
The facility's mean compliance rate for this requirement was 96%.

Other findings:
This monitor found compliance in three charts (AM, DL and RJS) and partial compliance in three (ALG, EC and MAS).

Current recommendations:
1. Ensure that the report addresses both psychosocial triggers of dangerousness and symptoms that triggered the instant offense.
2. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.
3. Continue to monitor this requirement based on a 50% sample.</td>
</tr>
<tr>
<td>D.7.a.iv</td>
<td>acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;</td>
<td>Current findings on previous recommendation:

Recommendation, June 2008:
Same as above.

Findings:
The following outlines the facility's mean compliance rates for the components of this requirement:

<table>
<tr><td>1.</td><td>Acceptance of mental illness</td><td>99%</td></tr>
<tr><td>2.</td><td>Understanding of the need for treatment</td><td>99%</td></tr>
<tr><td>3.</td><td>Understanding of the need to adhere to treatment</td><td>99%</td></tr>
</table>

Other findings:
This monitor found compliance in five charts (ALG, DL, EC, MAS and RJS) and partial compliance in one (AM).</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.
2. Continue to monitor this requirement based on a 50% sample.</td></tr>
<tr><td>D.7.a.v</td><td>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;</td><td>Current findings on previous recommendation:

Recommendation, June 2008:
Same as above.

Findings:
The facility's data are summarized as follows:

<table>
<tr><td>1.</td><td>Individual's development of relapse prevention plan for mental illness symptoms</td><td>99%</td></tr>
<tr><td>2.</td><td>Individual's recognition of precursors and warning signs and symptoms for dangerous acts</td><td>100%</td></tr>
</table>

Other findings:
This monitor found compliance in five charts (ALG, AM, EC, MAS and RJS) and partial compliance in one (DL).

Current recommendations:
1. Ensure that relapse prevention plans include specifics of the plan in all cases.
2. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements.
3. Continue to monitor this requirement based on a 50% sample.</td></tr>
<tr><td>D.7.a.vi</td><td>willingness to achieve understanding of substance abuse
issues and to develop an effective relapse</td><td>Current findings on previous recommendation:</td></tr>
</table>

	prevention plan (as defined above);	**Recommendation, June 2008:** Same as above. **Findings:** PSH reported a mean compliance rate of 100%. **Other findings:** Chart reviews by this monitor found compliance in two charts (EC and MAS) and noncompliance in one (DL). This requirement did not apply to the charts of ALG, AM and RJS. **Current recommendation**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 93%. **Other findings:** This monitor found compliance in all charts to which the requirement was applicable (ALG, DL and RJS). **Current recommendations**: 1. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements. 2. Continue to monitor this requirement based on a 50% sample.
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history	**Current findings on previous recommendation:**

	of sexual and emotional abuse, if applicable; and	**Recommendation, June 2008:** Same as above. **Findings:** The facility reported a mean compliance rate of 93%. **Other findings:** This monitor found compliance in all six charts reviewed. **Current recommendations**: Same as above.
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as above. **Findings:** PSH reported a mean compliance rate of 95%. **Other findings:** This monitor found compliance in three charts (ALG, DL and MAS) and partial compliance in one (RJS). The requirement was not applicable to the charts of AM and EC). **Current recommendations**: Same as above.
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370,	**Compliance:** Substantial.

	"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:	
D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as above. **Findings:** PSH provided formal PC 1370 Court Report Writing Training on September 30, 2008. The next scheduled training is planned for January 2009. The facility has continued to monitor 100% of the PC 1370 reports using the standardized DMH tool. The following summarizes the number of reports reviewed by the FRP each month during this reporting period:

Month	Reports reviewed
May 2008	121
June 2008	98
July 2008	94
August 2008	76
September 2008	70
October 2008	145

		The facility has maintained mean compliance rates greater than 90% for all the requirements in D.7.b since the last review. The rate was 100% for this requirement. The mean compliance rates for the requirements of D7.b.i through D7.b.iv are reported in each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. Comparative data are listed, as appropriate. **Other findings:** This monitor reviewed the charts of six individuals who were admitted under PC 1370 (AB, GAA, MDG, OG, PL and RJS). The review found compliance in five charts (AB, GAA, MDG, PL and RJS) and partial compliance in one (OG). **Current recommendations**: 1. Continue current practice and ensure ongoing training of WRPTs regarding compliance with EP requirements. 2. Continue to monitor this requirement based on a 50% sample.
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as above. **Findings:** PSH reported a mean compliance rate of 99% for this requirement. **Other findings:** This monitor found compliance in five charts (AB, GAA, MDG, PL and RJS) and partial compliance in one (OG).

<table>
<tr><td></td><td></td><td>Current recommendation:
Same as above.</td></tr>
<tr><td>D.7.b.iii</td><td>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and</td><td>Current findings on previous recommendation:

Recommendation, June 2008:
Same as above.

Findings:
The following is a summary of the facility's data:

<table>
<tr><td>1.</td><td>Description of any progress or lack of progress</td><td>99%</td></tr>
<tr><td>2.</td><td>Individual's response to treatment</td><td>99%</td></tr>
<tr><td>3.</td><td>Current relevant mental status</td><td>100%</td></tr>
<tr><td>4.</td><td>Reasoning to support the recommendations</td><td>100%</td></tr>
</table>

Other findings:
This monitor found compliance in five charts (AB, GAA, MDG, PL and RJS) and partial compliance in one (OG).

Current recommendation:
Same as above.</td></tr>
<tr><td>D.7.b.iv</td><td>all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.</td><td>Current findings on previous recommendation:

Recommendation, June 2008:
Same as above.

Findings:
The facility reported a mean compliance rate of 97%.

Other findings:
This monitor found compliance in the charts reviewed.</td></tr>
</table>

		Current recommendation: Same as above.
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction	**Current findings on previous recommendation:** **Recommendation, June 2008:** 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. **Findings:** The Chair of the FRP has been assigned supervisory status since September 2007. The facility has yet to provide administrative support to the FRP. The FRP has enlisted four additional part-time, intermittent reviewers (psychiatrists) to assist with the court report review process. These reviewers have helped to provide more detailed and specific feedback to court report writers. **Compliance:** Substantial. **Current recommendation**: Ensure that the FRP is able to perform its current duties regarding the review of reports, providing corrective feedback to practitioners and keeping adequate minutes of the FRP meetings.

D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** PSH has maintained current practice. PSH reported that all FRP members who review court reports continue to receive training on both group and individual bases. During this review period, the report reviewers received a series of mandatory didactic trainings provided by the Chair of the FRP that addressed various types of forensic reports. These trainings covered the following topics: 1. The legal basis of the Penal Code commitments, including landmark cases (*Dusky, Wilson, Godinez v. Moran, Indiana v. Edwards, Frendak, in re Hernandez, Sell v. U.S., Galindo*, etc); 2. A review of the DMH manual and an item-by-item discussion of each EP requirement; 3. The hospital's role in the treatment of these individuals and how the recovery model applies to their care; 4. The importance of appropriate documentation to support the opinions in the court reports; 5. The importance of malingering assessments in PC 1370 cases; 6. The importance of PC 1026 extensions and PC 2972 renewals, including the differences in the specific language required for each statute and the double jeopardy clause; 7. The role and function of the Conditional Release Program and the importance of collaboration with the CONREP care providers; and 8. The dual roles of evaluators and treatment providers and how to resolve conflicts that may arise between them **Compliance:** Substantial.

		Current recommendation: Continue current practice.

E. Discharge Planning and Community Integration		
		Summary of Progress: PSH did not make significant progress towards substantial compliance with EP requirements for this section during the most recent review period.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** <u>Interviewed</u>: 1. Edward Williams, LCSW, Family Services Coordinator 2. Hope Marriott, LCSW 3. Rachel Strydom, LCSW, (A) Supervising Social Worker 4. Veronica Kaufman, LCSW, Chief of Social Work <u>Reviewed</u>: 1. The charts of the following 17 individuals: CA, CS, GA, JJJ, JM, JO, MAO, NCC, PC, PCS, RM, RR, SB, SC, SO, SS and TY 2. List of individuals assessed to need family therapy 3. List of individuals assessed to need family education 4. List of individuals who met discharge criteria and are still hospitalized <u>Observed</u>: 1. WRPC for JC (Program 1, Unit 5) 2. WRPC for KDK (Program VI, Unit 71) 3. WRPC for MB (Program VI, Unit 71) 4. Pathways Intake To Orientation Mall Group 5. Court Preparation Mall Group 6. Stress Management Technique Mall Group 7. Fast Track PC 1370 Mall Group

E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	Please see sub-cells for compliance findings.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendations:** **Recommendations 1-3, June 2008:** • 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. • The individual's life goals should be linked to one or more focus/foci of hospitalization, with associated objectives and interventions. • Ensure that the individual's current WRP satisfies the necessary conditions to successfully meet discharge criteria. **Findings:** Interview of the Chief of Social Work and documentation review found that PSH provided training on Community Integration to Social Work staff, to WRPT mentors, and to five WRPTs per month. SW also offered monthly training on Focus 11. Using item 1 and sub-items from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data:

1.	*Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.*	6%
1.a	*There is at least one objective that is aligned with the individual's personal life goals that are stated*	20%

	on the first page of the WRP; and	
1.b	*The interventions will use the individual's strengths and preferences to achieve the respective objective.*	10%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	2%	6%
Compliance rate in last month of period		
1.	2%	5%
1.a	10%	19%
1.b	8%	5%

This monitor reviewed 13 charts (CS, GA, JJJ, JM, JO, MAO, NCC, PCS, RM, RR, SS and TY). Four of the WRPs in the charts (CS, PCS, RR and TY) had a focus of hospitalization with associated objectives and interventions linked to the individual's life goals. The remaining eight (GA, JJJ, JM, JO, MAO, NCC, RM and SS) did not.

This monitor reviewed 13 charts (CS, GA, JJJ, JM, MAO, NCC, PC, RM, RR, SB, SO, SS and TY). Seven of the WRPs in the charts (CS, GA, PC, RR, SB, SO and TY) had appropriate strengths identified in the intervention sections. The remaining six WRPs (JJJ, JM, MAO, NCC, RM and SS) did not have strengths identified in all the interventions or the stated strengths were nonspecific to the intervention.

As plan of correction, PSH will provide feedback to SW staff through their monthly newsletter, provide training modules to SW staff, mentors will train SW staff, the newly appointed section leader will

		focus on this section and work with Standards Compliance to coordinate requirements for compliance, and the section leader will conduct inter-rater agreement assessment for audits and carry out improvement plans to increase compliance. **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.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** 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:** Using item 2 and sub-items from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data: 2. *The individual's level of psychosocial functioning* 25% 2.a *The individual's level of psychosocial functioning is* 65%

	mentioned in the Present Status section of the WRP, and	
2.b	*The interventions linked to the discharge criteria are provided at the level of the individual's psychosocial functioning*	34%

Comparative data showed mixed changes in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
2.	28%	25%
Compliance rate in last month of period		
2.	31%	36%
2.a	73%	61%
2.b	35%	54%

This monitor reviewed 12 charts (GA, JJJ, JM, JO, MAO, NCC, RM, RR, SB, SC, SS and TY). Two of the WRPs in the charts (JM and RR) included the individual's level of psychosocial functioning in the Present Status section. The remaining ten (GA, JJJ, JO, MAO, NCC, RM, SB, SC, SS and TY) did not adequately address the individual's psychosocial functioning.

As plan of correction; PSH will have the new section leader focus on improving compliance of this section, and train the auditors to improve the inter-rater agreement.

Recommendation 2, June 2008:
Ensure that team members are aware of and trained in elements to consider in updating GAF scores.

		Findings: This monitor's interview of the Chief of Social Work found that PSH has included awareness and understanding of GAF scores as part of its WRP Discharge Planning Module. Training was conducted with various disciplines during this review period including Social Work, Rehabilitation Therapy Services, Psychology Services, Department of Medicine and Nursing. In the case of Nursing, PSH used the pyramidal model of training by training the ACNS staff, Nursing Coordinators and Unit Supervisors and then having them train the unit/program staff. The facility's plan of correction is the same as that described in E.1.a. **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. Ensure that team members are aware of and trained in elements to consider in updating GAF scores.
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendation 1 and 2,June 2008:** • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. **Findings:** According to the Chief of Social Work, PSH had taken a number of

steps to improve the timely discharge of individuals including CONREP participation and input (using Form MH 7021: CONREP Report for the Wellness and Recovery Planning Conference) in the seven-day conferences. In addition, PSH decided to open focus 11 in their WRPs.

Using item 3 and sub-items from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data:

3.	*Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.*	7%
3.a	*The individual's barriers to discharge, including difficulties encountered in previous placements are mentioned in the Present Status Section of the WRP.*	34%
3.b	*These barriers are listed in Focus 11, with appropriate objectives and interventions.*	13%

Comparative data showed improvement in compliance for all sub-items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
3.	7%	7%
Compliance rate in last month of period		
3.	3%	16%
3.a	36%	46%
3.b	5%	26%

		This monitor observed three WRPCs (JC, KDK and MB), in which none of the teams discussed fully the discharge barriers, progress towards discharge, and how to overcome the discharge barriers with the individuals. This monitor reviewed 11 charts (CS, GA, JJJ, JO, MAO, NCC, RM, SB, SC, SS and TY). Five of the WRPs in the charts (CS, JO, SB, SC and SS) contained documentation that discharge barriers were discussed with the individual. The remaining six (GA, JJJ, MAO, NCC, RM and TY) did not. Five charts (CS, GA, JO, NCC and SS) also had opened Focus 11 with appropriate objectives and interventions to assist the individual to overcome the discharge barriers. The facility's plan of correction is the same as that described in E.1.a. **Compliance:** Partial. **Current recommendations**: 1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. 2. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria.
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2008:** • Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. • Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual.

- Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary.

Findings:
According to the Chief of Social Work, PSH requires that all individuals in the facility be assigned to a discharge planning Mall group to ensure that the individual is well prepared for his/her discharge. Lesson plans have been developed for the discharge planning Mall groups. The discharge planning groups are organized at two levels for the individuals under PC 1370 and three levels for all other individuals. The SW department has established a clothing room to enable individuals to be properly clothed at the time of their discharge, and where possible, with advance notice, SW tries to have the individual's own clothing available at the time of discharge. PSH has also worked with the DMV for the discharged individuals to obtain their birth certificates and California IDs. PSH also made contact with all CONREP agencies requesting information about their programs, and the information was included into the Community Integration groups. In addition, CONREP representatives are also participating in groups as guest speakers

Using item 4 from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data:

4.	*The skills and supports necessary to live in the setting in which the individual will be placed.*	23%
4.a	*The Present Status section of the individual's WRP includes the anticipated discharge placement*	36%
4.b	*The scheduled PSR groups listed in the interventions include skills and supports the individual will need in the anticipated placement.*	43%

Comparative data showed modest improvement in mean compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
4.	10%	23%
Compliance rate in last month of period		
4.	16%	49%
4.a	23%	59%
4.b	30%	67%

This monitor reviewed 13 charts (CS, GA, JJJ, JO, MAO, NCC, PCS, RM, RR, SB, SC, SS and TY). Six of the WRPs (CS, JJJ, JO, PCS, SB and SC) contained documentation on the individual's needed skills and support. The information was included in the WRP and there were objectives and interventions for the individual to achieve the skills and supports necessary. The remaining seven (GA, MAO, NCC, RM, RR, SS and TY) did not have the skills and/or the supports needed for the individual's successful transition to the identified setting.

As plan of correction, PSH will provide feedback to SW staff through their monthly newsletter, provide training modules to SW staff, Mentors will train SW staff, and the newly appointed section leader will focus on this section and work with Standards Compliance to coordinate requirements for compliance.

Compliance:
Partial.

Current recommendations:
1. Assess the skills and supports that will be needed by the individual

		for a successful transition to the identified setting. 2. Include these skills and supports in the individual's WRP and use this information to guide appropriate services for the individual. 3. Ensure that WRPT members focus on this requirement and update the individual's WRP as necessary.
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Current findings on previous recommendations:** **Recommendations 1-3, June 2008:** • Ensure that the individual is an active participant in the discharge planning process. • Prioritize objectives and interventions related to the discharge process. • Ensure that the individual understands all of the discharge requirements before leaving the WRPC. **Findings:** Using item 12 from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 18% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data:

12.	*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.*	18%
12.a	*The WRPT asks the individual for his or her input into the evaluation of progress on each objective related to discharge.*	27%
12.b	*The WRPT asks the individual if he or she is able*	32%

	to easily understand the materials presented in the PSR Mall groups or individual therapy that are related to discharge criteria.	

Comparative data showed improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
12.	7%	18%
Compliance rate in last month of period		
12.	5%	40%
12.a	7%	62%
12.b	29%	47%

This monitor reviewed 12 charts (CS, GA, JJJ, JO, MAO, NCC, RM, RR, SB, SC, SS and TY). Nine of the WRPs in the charts (CS, GA, JJJ, JO, MAO, RM, SC, SS and TY) had documentation to show that the individual was an active participant in the discharge process. The remaining three (NCC, RR and SB) did not. Eight of the WRPs in the charts (CS, GA, JJJ, JO, RM, SC, SS and TY) prioritized the objectives and interventions related to the discharge process, and the remaining four (MAO, NCC, RR and SB) did not.

This monitor observed three WRPCs (KDK, JC, and MB). The WRPTs discussed the discharge criteria with the individuals and questioned the individuals to evaluate if the individuals understood the information.

The facility's plan of correction is the same as that described in E.1.a.

Compliance:
Partial.

		Current recommendations: 1. Ensure that the individual is an active participant in the discharge planning process. 2. Prioritize objectives and interventions related to the discharge process. 3. Ensure that the individual understands all of the discharge requirements before leaving the WRPC.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	**Compliance:** Partial.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual. **Findings:** Using item 6 from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data: *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:	
6.	*Measurable interventions regarding these discharge considerations*	17%
6.a	*The interventions are aligned with their respective objectives, and*	44%
6.b	*All objectives are written in a way that explains what the individual will do or learn, and how it will be measured.*	21%

Comparative data showed modest improvement in mean compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
6.	12%	17%
Compliance rate in last month of period		
6.	11%	39%
6.a	32%	76%
6.b	17%	42%

This monitor reviewed 12 charts (CS, GA, JJJ, JO, MAO, NCC, PCS, RM, SB, SC, SS and TY). Five of the WRPs in the charts (CS, JO, PCS, SB and SC) had the interventions written in behavioral and measurable terms. The remaining seven (GA, JJJ, MAO, NCC, RM, SS and TY) had one or more interventions not written in behavioral and measurable terms.

Compliance:
Partial.

		Current recommendation: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.
E.3.b	the staff responsible for implementing the interventions; and	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention. **Findings:** PSH's response, "This recommendation is not possible to achieve," is incorrect. This recommendation can and should be monitored. At the previous review, the Chief of Social Work had indicated that this recommendation can be audited when the MaPP system is linked to the WRP program. **Recommendation 2, June 2008:** Ensure that all elements required for fulfilling the intervention section of the WRP are completed. **Findings:** Using item 7 from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data: 7. *The interventions specify the name(s) of specific staff responsible for implementing each one* — 65%

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<td>Comparative data showed improvement in compliance since the last review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>7.</td><td>51%</td><td>65%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>7.</td><td>51%</td><td>84%</td></tr>
</table>
This monitor reviewed 12 charts (CS, GA, JJJ, JO, MAO, NCC, PCS, RM, SB, SC, SS and TY). Six of the WRPs in the charts (CS, GA, JO, PCS, SC and SS) contained interventions that included the necessary elements. The remaining six (JJJ, MAO, NCC, RM, SB and TY) did not.

Compliance:
Partial.

Current recommendations:
1. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.
2. Ensure that all elements required for fulfilling the intervention section of the WRP are completed.
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<tr>
<td>E.3.c</td>
<td>The time frames for completion of the interventions.</td>
<td>Current findings on previous recommendation:

Recommendation, June 2008:
Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.

Findings:
Using item 8 from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an</td>
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<td>average sample of 21% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data:
<table>
<tr><td>8.</td><td>A review date for each objective along with corresponding interventions is specified.</td><td>69%</td></tr>
</table>
Comparative data showed improvement in compliance since the last review as follows:
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>8.</td><td>38%</td><td>69%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>8.</td><td>42%</td><td>91%</td></tr>
</table>
This monitor reviewed 13 charts (CS, GA, JJJ, JO, MAO, NCC, PCS, RM, RR, SB, SC, SS and TY). Eight of the WRPs in the charts reviewed (CS, JJJ, SS, RM, MAO, NCC, SC and TY) had appropriate time frames for each objective and five of them (PCS, JO, SB, GA, and RR) did not.

Compliance:
Partial.

Current recommendation:
Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.
</td>
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<tr>
<td>E.4</td>
<td>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:</td>
<td>Compliance:
Partial.</td>
</tr>
</table>

E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Use objective data for all discharge criteria and planning. **Findings:** This monitor reviewed 12 charts (CS, GA, JJJ, JO, MAO, NCC, RM, RR, SB, SC, SS and TY). Seven of the WRPs in the charts (CS, JJJ, JO, RM, SB, SC and SS) used objective data consistently for all discharge criteria. The remaining five (GA, MAO, NCC, RR and TY) did not. A review of the list of individuals who met discharge criteria found that 67 of them were still in the hospital. A majority of these individuals met their readiness date within the last six months. There were three with readiness dates in the year 2007. One of the three was denied by CONREP, another has a December 2008 discharge date, and the third has been approved by CONREP and is awaiting Court hearing. According to the Chief of Social Work external factors including CONREP delays, Court hearing delays, and availability of suitable placements continue to be the barriers to a timely discharge. **Current recommendation**: Use objective data for all discharge criteria and planning.
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Document specific assistance provided to the individual when transitioned to a new setting. • 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, and documented in the individual's WRP.

Findings:
Using item 10 from the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 2% of the Quarterly and Annual WRPs due each month (May to October 2008). The table below is a summary of the data:

	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital share ensure that:	
10.	*Individuals receive adequate assistance in transitioning to the new setting. (E4b)*	6%
10.a	*The Present Status section of the individual's WRP describes the assistance needed to transition to the discharge setting; and*	16%
10.b	*Identifies the persons (i.e. agency staff) responsible for providing transitional assistance.*	6%

Comparative data showed slight improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
10.	2%	6%
Compliance rate in last month of period		
10.	2%	33%
10.a	7%	67%
10.b	2%	3

This monitor reviewed eight charts (CS, GA, JJJ, JO, PCS, RM, SB and

		SS). Four (CS, JO, PCS and SB) of the eight charts contained documentation that discussion was held with the individual on support and assistance the individual might need when transitioning to the new setting. Five of the WRPs in the charts (CS, GA, JO, PCS and SB) had documentation on the assistance that was provided to them. The remaining three (JJJ, RM and SS) did not contain documentation of any assistance provided to the individuals. **Current recommendations**: 1. Document specific assistance provided to the individual when transitioned to a new setting. 2. 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, and documented in the individual's WRP.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of Section E.5 are not applicable to PSH because it does not serve children or adolescents.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: 1. PSH has updated its Pharmacy and Therapeutics Manual consistent with current generally accepted standards. 2. DMH developed a standardized auditing tool regarding the use of new generation antipsychotic medications. The tool is consistent with current standards. PSH began implementation in September 2008. 3. PSH conducted adequate follow-up on Drug Utilization Evaluations that were completed during the previous reporting period. **Summary of Progress on Psychological Services:** 1. PSH has increased significantly the number of Behavior Guidelines developed and implemented during this review period. 2. PSH has established the Psychological Specialty Services Committee. The Committee meets regularly and its functioning is aligned with its goals and objectives. **Summary of Progress on Nursing Services:** 1. The Statewide Nursing Committee is currently developing a structure for shift report. 2. There has been an overall improvement in the nurses' documentation regarding medical changes in status and status upon transferring to and return from the community hospital/ER. 3. Ninety-five percent of Registered Nurses, 96% of Psychiatric Technicians and 95% of Licensed Vocational Nurses have received and passed the WRP Level 1 training. **Summary of Progress on Rehabilitation Therapy Services:** 1. 179 Rehabilitation Therapy 12-week lesson plans were developed for Rehabilitation Therapy PSR Mall groups. 2. An F.4 Monitoring tool has been developed and implemented.

	3. Significant progress has been made in the area of Vocational Services program development. 4. Data analysis based on requisite audit samples for each area of F.4 has been initiated. This process should continue to be developed to ensure that the facility provides a thorough and meaningful analysis of all sub-items below 90% compliance, with appropriate plans of correction to improve compliance implemented as needed. This self-assessment should be consistent with the self-assessment specifications found in the introduction of this report. **Summary of Progress on Nutrition Services:** 1. Review of data from the Meal Accuracy report shows substantial compliance with tray accuracy. 2. A draft proposal for an Interdisciplinary Weight Management PSR Mall group has been developed and is pending approval and implementation. **Summary of Progress on Pharmacy Services:** 1. PSH has increased the number and range of pharmacy recommendations to prescribing physicians regarding new orders or changes in existing orders of psychiatric medications. 2. PSH has improved the rate of physicians' responses to pharmacy recommendations. **Summary of Progress on General Medical Services:** 1. PSH implemented the Medical Risk Management Committee to review the status of individuals with high-risk medical concerns, including individuals following outside hospitalization for acute care. 2. The DMH developed a draft SO for Risk Management that includes adequate mechanisms to address physical risk factors. 3. The DMH developed draft revisions of the formats and protocols of nursing assessment and documentation of change in the physical status of individuals. If properly finalized and implemented, these

	tools can facilitate compliance with the EP in the areas of medical and nursing services. **Summary of Progress on Infection Control:** 1. PSH's Infection Control Department has achieved and maintained substantial compliance with most EP requirements. 2. PSH's Infection Control Department, in conjunction with the Department of Medicine and Nursing Services, has implemented a number of strategies to increase compliance regarding infection control issues related to Focus 6 and the WRPs. 3. PSH will be implementing an Immunization/PPD team who will administer all the required immunizations and PPDs. **Summary of Progress on Dental Services** 1. PSH's Dental Department has achieved and maintained substantial compliance with many EP requirements. 2. PSH will begin implementation of the new Dental Software package by the next review.

1. Psychiatric Services		
		Methodology: Interviewed: 1. George Christison, MD, Acting Chief of Psychiatry 2. Rebecca Kornbluh, MD, Chief of Professional Education 3. Steven Mauer, MD, President, Medical Staff Reviewed: 1. The charts of the following 39 individuals: AAC, AT, CCN, CES, DBP, FMD, GA, GP, GWD, JBW, JHB, JJM, JJM, JLC, JLK, JM, JS, JSN, JW, JWP, KJF, MAT, MEH, MO, MS, NM, NMM, PFC, RA, RAG, RAS, RGM, RJH, RR, RVM, RWT, SS, TK and WRW 2. PSH Pharmacy and Therapeutics Manual, revised 3. DMH Admission Psychiatric Assessment Auditing Form 4. DMH Admission Psychiatric Assessment Auditing Form Instructions 5. PSH Admission Psychiatric Assessment Auditing summary data (May to October 2008) 6. DMH Integrated Assessment: Psychiatry Section Auditing Form 7. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 8. PSH Integrated Assessment: Psychiatry Section Auditing summary data (May to October 2008) 9. DMH Monthly Psychiatric Progress Notes Auditing Form 10. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions 11. PSH Monthly Psychiatric Progress Notes Auditing summary data (May to October 2008) 12. DMH Nursing Services Monitoring Form (PRN) 13. DMH Nursing Services Monitoring Form (Stat) 14. PSH summary data of PRN/Stat medication use (May to October 2008) 15. DMH Benzodiazepine Auditing Form

		16. DMH Benzodiazepine Auditing Form Instructions 17. PSH Benzodiazepine Auditing summary data (May to October 2008) 18. DMH Anticholinergic Auditing Form 19. DMH Anticholinergic Auditing Form Instructions 20. PSH Anticholinergic Auditing summary data (May to October 2008) 21. DMH Polypharmacy Auditing Form 22. DMH Polypharmacy Auditing Form Instructions 23. PSH Polypharmacy Auditing summary data (May to October 2008) 24. DMH New Generation Antipsychotic Monitoring Form 25. DMH New Generation Antipsychotic Monitoring summary data (May to October August, 2008) 26. PSH Tardive Dyskinesia Database 27. DMH Tardive Dyskinesia (TD) Auditing Form 28. DMH TD Auditing Form Instructions 29. PSH TD Auditing summary data (May to October 2008) 30. PSH data regarding Adverse Drug Reactions (ADRs) and Medication Variances (May to October 2008) 31. Last ten completed ADR reporting forms 32. PSH Intensive Case Analyses (#4) for ADRs during this review period 33. PSH Drug Utilization Evaluations completed during this reporting period 34. Last ten completed medication variance reporting forms 35. Minutes of the Pharmacy and Therapeutics (P&T) Committee meetings (May to October 2008)
F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Finalize individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary. • Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant

	psychotropic medications to ensure that they are:	clinical experience and professional practice guidelines. **Findings:** PSH updated its Pharmacy and Therapeutics Manual including medication guidelines in the following areas: 1. Time limit for ordering PRN medications (not exceeding 15 days); 2. Requirement for follow-up electrocardiogram for individuals receiving tricyclic antidepressant medications; 3. Early monitoring of plasma concentrations of divalproex; 4. Monitoring of plasma levels of lamotrigine in some cases; 5. Revised dose limit of olanzapine; 6. Use of antipsychotics with adjunctive medications (duloxetine, oxcarbazepine, tiagabine, eszopiclone or zalepon); 7. Use of Lovaza for treatment of hypertriglyceridemia; 8. Consideration of MRI for individuals with hyperprolactinemia; and 9. Dosing strategies to decrease risk of seizure induction during treatment with buproprion. **Recommendation 3, June 2008:** Finalize the DMH auditing form regarding the use of new generation antipsychotic medications. **Findings:** The DMH has finalized this instrument and PSH began implementation in September 2008. **Recommendations 4 and 5, June 2008:** • Monitor these requirements using the standardized DMH tools based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

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Findings:
To assess compliance, PSH used the previously mentioned DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms based on average samples of 54%, 30% and 15%, respectively. The compliance data are summarized in each cell below. The facility's plan of correction is the same as that outlined in D.1.a.

Other findings:
See this monitor's findings in D.1.c.ii, D.1.c.iii, D.1.d.i and D.1.f.

Compliance:
Partial.

Current recommendations:
1. Finalize individualized guidelines for all psychotropic and anticonvulsant medications listed in the formulary.
2. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. Provide a summary outline of the revisions made during the review period.
3. Monitor these requirements using the standardized DMH tools based on at least a 20% sample.
4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

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<tr>
<td>F.1.a.i</td>
<td>specifically matched to current, clinically justified diagnoses or clinical symptoms;</td>
<td>

<table>
<tr><td colspan="3">Admission Psychiatric Assessment</td></tr>
<tr><td>8.</td><td>Plan of care includes:</td><td>85%</td></tr>
<tr><td>8.a</td><td>Regular psychotropic medications, with rationale</td><td>88%</td></tr>
<tr><td>8.b</td><td>PRN and/or Stat medication as applicable, with</td><td>68%</td></tr>
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</table>

	specific behavioral indications	
8.c	*Special precautions to address risk factors, as indicated*	85%

Comparative data showed some improvement in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
8.	83%	85%
Compliance rate in last month of period		
8.a	67%	95%
8.b	N/A	100%
8.c	100%	100%

Integrated Psychiatric Assessment		
7.	*Diagnostic formulation is documented.*	94%
10.	*Psychopharmacology treatment plan includes:*	45%
10.a	*Current target symptoms;*	63%
10.b	*Specific medication to be used;*	97%
10.c	*Dosage titration schedules, if indicated;*	86%
10.d	*Adverse reactions to monitor for;*	56%
10.e	*Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation antipsychotics;*	81%
10.f	*Response to medication since admission, if applicable, including PRN and Stat medications;*	61%
10.g	*Medication consent issues were addressed.*	95%

Comparative data showed mixed changes since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	88%	94%
10.	53%	45%
Compliance rate in last month of period		
7.	62%	58%
10.	72%	67%
10.a	100%	100%
10.b	94%	88%
10.c	72%	59%
10.d	55%	100%
10.e	100%	100%
10.f	99%	100%
10.g	62%	58%

Monthly PPN		
2.b	*The current target symptoms which are the focus of treatment are identified in the progress note.*	87%
6.a.1	*The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	76%
6.a.2	*There is a clear description of the reasoning for continuing the current medication regiment and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.*	76%

Comparative data showed improvement in compliance since the last review as follows:

<table>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.b</td><td>70%</td><td>87%</td></tr>
<tr><td>6.a.1</td><td>38%</td><td>76%</td></tr>
<tr><td>6.a.2</td><td>31%</td><td>76%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.b</td><td>75%</td><td>94%</td></tr>
<tr><td>6.a.1</td><td>53%</td><td>72%</td></tr>
<tr><td>6.a.2</td><td>54%</td><td>72%</td></tr>
</table>
</td></tr>
<tr><td>F.1.a.ii</td><td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td><td>PSH reported a mean compliance rate of 75%, compared to 50% during the last review. The rate for the last month of this review period was 76% compared to 51% during the last month of the previous review period.</td></tr>
<tr><td>F.1.a.iii</td><td>tailored to each individual's symptoms;</td><td>Same as in F.1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented.</td><td>87%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>87%</td></tr>
<tr><td>2.d</td><td>Progress towards objective in the Wellness and Recovery Plan (is documented).</td><td>81%</td></tr>
</table>
Comparative data showed improvement in compliance since the last review as follows:
</td></tr>
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	Previous period	Current period
Mean compliance rate		
2.b	70%	87%
2.c	67%	87%
2.d	56%	81%
Compliance rate in last month of period		
2.b	75%	94%
2.c	74%	90%
2.d	61%	82%

F.1.a.v monitored appropriately for side effects;

Monthly PPN		
6.b	*Monitoring of side effects (is documented).*	78%
6.c	*AIMS is completed.*	84%

Comparative data showed mixed changes as follows:

	Previous period	Current period
Mean compliance rate		
6.b	54%	78%
6.c	77%	84%
Compliance rate in last month of period		
6.b	73%	83%
6.c	93%	81%

<table>
<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.a.1</td><td>The risks, benefits and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td>76%</td></tr>
<tr><td>6.a.2</td><td>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</td><td>76%</td></tr>
</table>

Comparative data showed improved compliance since the last review as follows:

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>6.a.1</td><td>45%</td><td>76%</td></tr>
<tr><td>6.a.2</td><td>31%</td><td>76%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>6.a.1</td><td>53%</td><td>72%</td></tr>
<tr><td>6.a.2</td><td>54%</td><td>72%</td></tr>
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</td></tr>
<tr><td>F.1.a.vii</td><td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>87%</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects (is documented).</td><td>78%</td></tr>
<tr><td>6.c</td><td>AIMS is completed.</td><td>84%</td></tr>
</table>

Comparative data showed improved compliance for most items since the last review as follows:
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<tr><td></td><td></td><td>
<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.c</td><td>67%</td><td>87%</td></tr>
<tr><td>6.b</td><td>54%</td><td>78%</td></tr>
<tr><td>6.c</td><td>77%</td><td>84%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.c</td><td>74%</td><td>90%</td></tr>
<tr><td>6.b</td><td>73%</td><td>83%</td></tr>
<tr><td>6.c</td><td>93%</td><td>81%</td></tr>
</table>
</td></tr>
<tr><td>F.1.a.viii</td><td>Properly documented.</td><td>The facility provided the following weighted means for all items above:
<table>
<tr><td>Admission Psychiatric Assessment</td><td>8.a, 8.b and 8.c</td><td>85%</td></tr>
<tr><td>Integrated Assessment (Psychiatry)</td><td>7 and 10</td><td>69%</td></tr>
<tr><td>Monthly PPN</td><td>2.b, 2.c, 2.d, 2.h.2, 6.a.1, 6.a.2, 6.b and 6.c</td><td>81%</td></tr>
</table>
</td></tr>
<tr><td>F.1.b</td><td>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.</td><td>Current findings on previous recommendations:

Recommendations 1,2 and 3, June 2008:
• Monitor the use of PRN and Stat medications based on at least a 20% sample and provide data analysis regarding low compliance with accompanying corrective actions.
• Continue to report data regarding PRN and Stat medications to address EP requirements regarding each of the following:
o Psychiatric documentation of PRN medication use;
o Psychiatric documentation of Stat medication use;
o Nursing documentation of PRN medication use; and</td></tr>
</table>

- o Nursing documentation of Stat medication use.
- Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
PSH used the DMH standardized Monthly PPN tool to audit this requirement. The average sample size was 76% of individuals who have been hospitalized for 90 or more days (May to October 2008). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses. The average samples were 15% and 21% of PRN and Stat medications given per month, respectively. The following is a summary of the data:

Monthly PPN		
7.	*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:*	48%
7.a	*Describes the rationale/specific indications for all PRN orders;*	61%
7.b	*Reviews the PRNs and Stats during the interval period;*	62%
7.c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions;*	42%
7.d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/Stat medications.*	36%

Comparative data showed mixed changes since the last review as follows:

	Previous period	Current period
Mean compliance rate		
7.	25%	48%
Compliance rate in last month of period		
7.	25%	42%
7.a	47%	51%
7.b	65%	45%
7.c	33%	26%
7.d	20%	15%

Nursing Services PRN		
1.	*Safe administration of PRN medication*	94%
2.	*Documentation of the circumstances requiring PRN medication*	79%
3.	*Documentation of the individual's response to PRN medication*	15%

Comparative data showed some improvement in compliance for several items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	97%	94%
2.	55%	79%
3.	3%	15%
Compliance rate in last month of period		
1.	No data	No data
2.	77%	76%
3.	0%	20%

Nursing Services Stat		
1.	*Safe administration of Stat medication*	89%
2.	*Documentation of the circumstances requiring Stat medication*	63%
3.	*Documentation of the individual's response to Stat medication*	12%

Comparative data showed mixed changes since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	92%	89%
2.	57%	63%
3.	20%	12%
Compliance rate in last month of period		
1.	100%	89%
2.	67%	59%
3.	17%	23%

In addition to the corrective actions outlined in DF.1.a, PSH reported the following:

1. The Medical Director and Chief of Staff directed all physicians giving orders for Stat medications to write a note within 24 hours of the order and document review of the individual's response to the Stat medication in the monthly PPN.
2. The facility plans to change the policy for documentation of response to Stat medications to reflect EP audit requirements and

		to include requirements regarding PRN and Stat medications in the quarterly audit performance profile. **Other findings:** See this monitor's findings in D.1.f. **Compliance:** Partial. **Current recommendations**: 1. Update the facility's procedures regarding PRN and Stat medications to ensure physician's review and documentation of the circumstances leading to the use of these medications, adjustment of regular treatment as needed based on PRN and/or Stat medication use and face-to-face evaluation of the individuals within 24 hours of Stat medication use. 2. Monitor the use of PRN and Stat medications based on at least a 20% sample. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendations 1,2 and 3 June 2008:** • Monitor this requirement using the DMH standardized tools based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). • Provide ongoing feedback and mentoring by senior psychiatrists to ensure correction of deficiencies noted by this monitor.

Findings:
PSH used the DMH Benzodiazepine, Anticholinergics and Polypharmacy Audit Forms to assess compliance (May to October 2008). The following is a summary outline of the monitoring indicators, corresponding mean compliance rates and comparative data, as applicable.

Benzodiazepines (average sample has varied depending on the indicator, ranging from 13 to 17% of all individuals receiving regularly scheduled benzodiazepines)		
1.	*Indication for regularly scheduled use of benzodiazepine clearly documented in medical record*	35%
2.	*Benzodiazepine used for individuals with alcohol/drug use problems justified in PPN*	32%
3.	*Benzodiazepine used for individuals with cognitive disorders justified in PPN*	14%
	Routine benzodiazepine use for more than two months, PPN clearly documents the risks of:	
4.	*Drug dependence*	18%
5.	*Cognitive decline*	10%
6.	*Sedation*	24%
7.	*Gait unsteadiness / falls if indicated*	12%
8.	*Respiratory depression (for those with underlying respiratory problems e.g. COPD)*	8%
9.	*Toxicity if used in individuals with liver impairment (if using long acting agents)*	29%
10.	*Treatment modified in an appropriate and timely manner to ensure proper indications and to minimize risk.*	34%

Comparative data showed improvement in compliance for many items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	34%	35%
2.	22%	32%
3.	14%	14%
4.	14%	18%
5.	8%	10%
6.	10%	24%
7.	2%	12%
8.	6%	8%
9.	33%	29%
10.	35%	34%
Compliance rate in last month of period		
1.	31%	38%
2.	14%	44%
3.	0%	0%
4.	9%	25%
5.	0%	24%
6.	0%	24%
7.	0%	18%
8.	0%	20%
9.	N/A	50%
10.	10%	62%

Anticholinergics (average sample has varied depending on the indicator, ranging from 11 to 13% of all individuals receiving regularly scheduled anticholinergics)		
1.	*Indication for use of anticholinergic clearly documented in PPN (N = All individuals on any of the four anticholinergics)*	38%

	Regularly scheduled anticholinergics for more than two months clearly documented in the PPN risks of: (N= All individuals over age 60 and with cognitive impairment of any type for #2-6)	
2.	*Cognitive impairment*	19%
3.	*Sedation*	44%
4.	*Gait unsteadiness/falls*	20%
5.	*Blurred vision, constipation, urinary retention*	19%
6.	*Worsening narrow angle glaucoma*	67%
	Regularly scheduled anticholinergics use for more than 2 months clearly document in PPN risks of: (N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for #7-13)	
7.	*Cognitive impairment*	11%
8.	*Sedation as indicated*	20%
9.	*Gait unsteadiness / falls (as indicated)*	13%
10.	*Blurred vision, constipation, urinary retention*	8%
11.	*Worsening narrow angle glaucoma, if present*	8%
12.	*Substance abuse/dependence if listed on Axis I*	16%
13.	*Worsening TD if present*	23%
14.	*Dosage is within DMH psychotropic medication policy (unless TRC/MRC consult was obtained); N= all individuals on the four anticholinergics for #14.*	89%
15.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk; N= all individuals on anticholinergics for more than two months regardless of age or cognitive status for #15.*	41%

Comparative data showed improvement in compliance with most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	12%	38%
2.	18%	19%
3.	22%	44%
4.	0%	20%
5.	0%	19%
6.	N/A	67%
7.	8%	11%
8.	3%	20%
9.	5%	13%
10.	0%	8%
11.	0%	8%
12.	39%	16%
13.	0%	23%
14.	92%	89%
15.	33%	41%
Compliance rate in last month of period		
1.	25%	19%
2.	17%	0%
3.	0%	0%
4.	0%	0%
5.	0%	0%
6.	N/A	N/A
7.	0%	23%
8.	0%	7%
9.	0%	14%
10.	0%	7%
11.	0%	0%
12.	0%	13%
13.	0%	0%

14.	92%	100%
15.	10%	60%

Polypharmacy (average S varied depending on indicator, ranging from 10% to 11% of individuals receiving inter or intra-class polypharmacy)		
1.	*Target symptoms were clearly identified.*	71%
2.	*Documentation in PPN justifies the need for inter-class polypharmacy.*	35%
3.	*Documentation in PPN justifies the need for intra-class for polypharmacy.*	34%
4.	*The PPN documents the risks of the polypharmacy including drug-to-drug interactions.*	16%

Comparative data showed improvement in compliance with most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	34%	71%
2.	17%	35%
3.	21%	34%
4.	9%	16%
Compliance rate in last month of period		
1.	53%	71%
2.	28%	48%
3.	36%	36%
4.	21%	15%

PSH's corrective actions were the same as those outlined in D.1.a. In addition, the facility reported that a case conference will be provided

		regarding the risks of anticholinergic and benzodiazepine use and modification of the progress notes template will be considered to emphasize high-risk medication uses. **Recommendation 4, June 2008:** Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions. **Findings:** The facility's data and corrective actions related to above recommendations are aligned with this recommendation. **Other findings:** This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following regimens: 1. Benzodiazepines in the presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. This monitor reviewed the charts of 21 individuals receiving the above types of medication regimens. There continues to be a pattern of long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) and/or polypharmacy without documented justification and/or assessment of the individuals for the risks associated with this practice. The following tables outlines these reviews (diagnoses are listed only if they signified conditions that increased the risk of use):

Benzodiazepine use

Individual	Medication(s)	Diagnosis
AAC	Clonazepam	Polysubstance Dependence
DBP	Clonazepam	Polysubstance Dependence
JBW	Lorazepam	Polysubstance Dependence
JJM	Alprazolam	Other Substance Dependence
JS	Lorazepam	Polysubstance Dependence
MO	Lorazepam	Other Substance Abuse
RAS	Clonazepam	Alcohol Dependence
RVM	Lorazepam	Alcohol Abuse

Anticholinergic use

Individual	Medication(s)	Diagnosis
CES	Benztropine	Cognitive Disorder NOS
JLK	Diphenhydramine	Borderline Intellectual Functioning
JSN	Benztropine	Cognitive Disorder NOS
NM	Benztropine	Borderline Intellectual Functioning
RA	Benztropine	Mild Mental Retardation
RAG	Diphenhydramine	Borderline Intellectual Functioning
RR	Benztropine	Borderline Intellectual Functioning
RWT	Benztropine	Borderline Intellectual Functioning

Polypharmacy use

Individual	Medication(s)	Diagnosis
GA	Haloperidol, risperidone, quetiapine, lorazepam, lithium and lamotrigine	Polysubstance Dependence

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<tr><td>JLC</td><td>Clozapine, haloperidol, olanzapine, buproprion, lamotrigine, lorazepam, zolpidem and diphenhydramine</td><td>Alcohol Dependence</td></tr>
<tr><td>JW</td><td>Haloperidol, olanzapine, quetiapine and lorazepam</td><td>Polysubstance Dependence</td></tr>
<tr><td>MS</td><td>Clozapine, haloperidol, risperidone, benztropine, diphenhydramine and divalproex</td><td></td></tr>
<tr><td>RJH</td><td>Loxapine, quetiapine, trifluperazine, lorazepam, trazodone and divalproex</td><td></td></tr>
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Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the DMH standardized tools based on at least a 20% sample.
2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
3. Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of the deficiencies noted by this monitor.
4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.
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<tr>
<td>F.1.d</td>
<td>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</td>
<td>Current findings on previous recommendations:

Recommendations 1-4, June 2008:
• Implement corrective action to improve documentation of the</td>
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rationale for prescribing high-risk antipsychotic treatment for individuals at risk of metabolic disorders, including Diabetes Mellitus.

- Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of deficiencies noted by this monitor.
- Monitor this requirement using the DMH standardized tool based on at least a 20% sample.
- Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.

Findings:
During this reporting period, the DMH developed a standardized auditing tool regarding the use of new generation antipsychotic medications. The tool is consistent with current standards. Using the standardized tool, PSH assessed its compliance (September to October 2008) based on average sample of 9% of individuals receiving these medications. The following is a summary of the data:

1.	*Indications for use are documented in the PPN*	85%
2.	*Absolute contraindications are absent*	98%
3.	*Relative contraindications are absent unless benefits outweigh risks*	92%
4.	*Family/personal risk factors addressed in PPN (if medication started within last 90 days)*	14%
	Justification for use documented in PPN for individuals with diagnosis of (for olanz, risp, quet)	37%
5.	*Dyslipidemia*	38%
6.	*Diabetes*	44%
7.	*Obesity*	11%
8.	*Justification for use documented in PPN for individuals on risperidone with hyperprolactinemia*	94%
9.	*Dose initiation meets requirements*	92%
10.	*Dose titration meets requirements*	40%

		11.	*Appropriate monitoring for postural hypotension for individual >60y/o with BP<90/60*	58%
		12.	*ECG within previous 12 months*	41%
		13.	*Semiannual ECG for individuals on ziprasidone*	37%
		14.	*If given a concurrent medication that prolongs the QTC, a semiannual ECG was done*	55%
		15.	*Monitoring the Vital signs*	67%
			Appropriate baseline and regular monitoring of:	
		16.	*Body mass index*	63%
		17.	*Waist circumference*	57%
		18.	*Fasting blood sugar initially*	85%
		19.	*Fasting Blood Sugar (FBS) monthly for the first six months (clozapine and olanzapine only)*	59%
		20.	*FBS quarterly (including olanzapine and clozapine after first 6 months)*	65%
		21.	*Triglycerides*	82%
		22.	*Cholesterol*	82%
		23.	*HgbA1C if FBS high*	68%
		24.	*Prolactin level (annually, and initially for risperidone and paliperidone only)*	51%
		25.	*Breast exam*	34%
		26.	*AIMS exam*	74%
		27.	*Serum amylase/lipase*	48%
		28.	*If an unstable seizure disorder is present, a Neurology consultation was ordered*	79%
		29.	*There is documentation of potential and actual risk for each medication used*	37%
		30.	*Treatment was modified in an appropriate and timely manner to address identified risks*	90%
		31.	*For Clozapine only, the DMH Psychotropic Guidelines were followed for changes in WBC/ANC*	88%

Comparative data were not available due to recent implementation of this tool. PSH's corrective actions were the same as those outlined in D.1.a. In addition, the facility reported that compliance should be enhanced by the following actions:

1. Improved distribution and access to medication protocols;
2. Improved training to auditors;
3. Training on antipsychotic medication risks jointly with the Department of Medicine;
4. Reconciling data from this audit with data from the PPN audit; and
5. Presentations to medical staff dedicated to exploring the metabolic impact of new generation antipsychotics (two lectures were provided during this reporting period).

Other findings:
This monitor reviewed the charts of 12 individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	Medication(s)	Diagnosis
AT	Risperidone	Obesity
CCN	Olanzapine	Pure hypertriglyceridemia and metabolic syndrome
JJM	Clozapine	Dyslipidemia and diabetes mellitus Type II
JM	Risperidone	Hyperlipidemia and obesity
JWP	Olanzapine	Hypertriglyceridemia and obesity
KJF	Quetiapine	Diabetes mellitus and obesity
MAT	Risperidone	Hypercholesterolemia and obesity
MEH	Olanzapine	Unspecified hyperlipidemia
NMM	Risperidone	Hyperprolactinemia

PFC	Quetiapine and olanzapine	Diabetes mellitus, hypertriglycer-idemia and obesity
RGM	Clozapine	Hyperlipidemia
WRW	Olanzapine	Dyslipidemia

In general, the facility provided adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. During this review period, the facility appeared to have improved laboratory monitoring of the risks of endocrine and pancreatic dysfunction using serum prolactin and lipase/amylase, respectively. However, this monitor found a pattern of persistent process deficiencies that must be corrected to achieve substantial compliance. The following are examples:

1. The psychiatric progress notes did not address the risk of persistent hyperlipidemia in an individual receiving high-risk treatment with clozapine (RGM).
2. The psychiatric progress notes did not track the weight status of an individual who was diagnosed with hypertriglyceridemia and experiencing significant weight increase (up to BMI of 38) while receiving high-risk treatment with olanzapine.
3. The chart did not include evidence that the weight of an individual receiving high-risk treatment with olanzapine was being monitored as required. The individual was diagnosed with obesity and hypertriglyceridemia (JWP).
4. The WRP did not include diagnoses of dyslipidemia and diabetes mellitus for an individual who carried these diagnoses as per the medical conditions list (JJM). The individual received high-risk treatment with clozapine. However, the WRP included foci and objectives/interventions related to these diagnoses.
5. The psychiatric progress notes did not track the status of the above-mentioned individual's weight, which is relevant to the metabolic risks associated with this treatment.

		6. There was evidence of inadequate monitoring of serum prolactin in a female individual receiving high-risk treatment with risperidone (AT). The psychiatric progress notes did not address the endocrine risks associated with this treatment. 7. The psychiatric progress notes did not track the laboratory and/or clinical status of a female individual who was receiving high-risk treatment with risperidone (NMM). The individual was diagnosed with hyperprolactinemia as per the medical conditions list, but the psychiatric notes did not identify or address this diagnosis. 8. The psychiatric progress notes did not track serum lipids and weights in an individual diagnosed with hyperlipidemia and obesity and receiving high-risk treatment with risperidone (JM). 9. The WRP did not include diagnosis, focus or objective/interventions related to obesity in an individual who was diagnosed with this condition and receiving high-risk treatment with risperidone (MAT). 10. The psychiatric progress notes did not address the risks of recent development of new-onset diabetes mellitus in an individual who was receiving high-risk treatment with quetiapine and olanzapine (PFC). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH standardized tools based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 3. Provide ongoing feedback and mentoring by Senior Psychiatrists to ensure correction of the deficiencies noted by this monitor. 4. Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.

F.1.e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the DMH standardized tool based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** PSH used the DMH Tardive Dyskinesia Auditing Form to assess compliance. The average sample ranged from 12% to 59% depending on the indicator. However, the data are not presented in this report because the facility acknowledged that its data collection was unreliable regarding this audit and that many individuals identified as having TD did not have that diagnosis in a spot audit of a few charts. The facility reported that its Standards Compliance Department has developed a corrective action plan. **Recommendation 3, June 2008:** Develop and implement a policy and procedure to ensure that: a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. **Findings:** PSH did not adequately address this recommendation during this reporting period. However, the facility reported a plan to develop a specialized TD clinic; no timeframes were provided.

		Recommendation 4, June 2008: Update the staff psychiatrist manual to include the standards outlined in the policy/procedure. **Findings:** PSH has yet to implement this recommendation. **Other findings:** This monitor reviewed the charts of six individuals (FMD, GP, GWD, JHB, SS and TK) who were diagnosed with tardive dyskinesia as per the facility's database. The database identified 181 individuals as meeting one of the following three criteria: current diagnosis of TD, history of TD or current abnormal AIMS score. This review found that the admission AIMS tests were completed in all the charts of individuals who were admitted during the past year. A few charts documented attempts to use safer treatment alternatives (GP and JHB). None of the individuals reviewed received unjustified long-term treatment with anticholinergic agents. However, the review found a pattern of deficiencies as follows: 1. The psychiatric progress notes did not track or address the status of involuntary movements in individuals diagnosed with current TD (e.g. SS). 2. There was no evidence that a neurology consultation was completed for some individuals who were diagnosed with Abnormal Involuntary Movements. 3. Some WRPs did not include focus statement or objectives/ interventions to address current diagnosis of TD (GWD) or R/O TD (GP). 4. Some WRPs (e.g. TK) included TD-related objectives that were not appropriate or attainable for the individual (e.g. requesting PRN

		medications to control the symptoms of TD). 5. The AIMS tests were not completed quarterly as required in all the charts reviewed. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH standardized tool based on at least a 20% sample and ensure accuracy of data. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 3. Develop and implement a policy and procedure to ensure that: a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. 4. Update the staff psychiatrist manual to include the standards outlined in the policy/procedure.
F.1.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:** **Recommendations 1 and 2, June 2008:** • Increase reporting of ADRs. • Continue review and analysis of ADRs and present summary of aggregated data to address the following: o The number of ADRs reported each month during the review period compared with number reported during the previous period.

		o Classification of probability and severity of ADRs. o Any negative outcomes for individuals who were involved in serious reactions. o Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions. o Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). **Findings:** During this review period, PSH reported 55 ADRs compared to 41 during the previous period. Most of the increase in ADRs during this period was reportedly due to ADRs that were classified as Doubtful or Probable and ADRs that were rated as Mild. The classification by probability also showed that 21 reactions were rated as probable and one as definite. Although no reaction was rated as Severe, PSH conducted five intensive case analyses (ICAs) on the following ADRs: 1. Acute EPS when transitioning from aripiprazole to ziprasidone; 2. Priapism secondary to risperidone; 3. Pneumonia secondary to pegylated interferon and ribavirin; and 4. Rhabdomyolysis secondary to simvastatin. The above ICAs were based on adequate methodology and the recommendations for performance improvement were appropriate. **Compliance:** Partial. **Current recommendations**: 1. Increase reporting of ADRs.

		2. Continue review and analysis of ADRs and present summary of aggregated data to address the following: a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and 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:** **Recommendations 1 and 2, June 2008:** • Continue DUEs that include review of use; analysis of trends/patterns; conclusions regarding findings; and recommendations for corrective actions/educational activities based on the review. • Provide a summary outline of corrective actions to address recommendations of the four DUEs completed during this reporting period. **Findings:** PSH has implemented these recommendations. During this review period, the facility conducted the following DUEs: 1. Measurement of the impact of a Medical Risk Factor Mall group on waist circumference and BMI (new research plus a follow-up on

		DUE for the Metabolic Syndrome conducted during the previous period). This DUE showed that enrollment in the Medical Risk Factor Group was correlated with a statistically significant decrease in BMI. 2. Follow-up on DUEs for Olanzapine (in individuals with diabetes mellitus) and New Generation Antipsychotic Medication conducted during the previous period. The main finding was that unit psychiatrists were still not adequately justifying the use of olanzapine in individuals with diabetes mellitus; corrective actions were developed. 3. Divalproex use for approved diagnosis and monitoring of use. This DUE found that the medication was used for appropriate diagnosis but that laboratory monitoring was inadequate; corrective actions were developed. The above DUEs employed adequate methodology and their conclusions, recommendations and corrective actions were appropriate. **Compliance:** Partial. **Current recommendations**: 1. Conduct further DUEs based on a specified calendar and ensure that all DUEs include review of use; analysis of trends/patterns; conclusions regarding findings; and recommendations for corrective actions/educational activities based on the review. 2. Provide a summary outline of corrective actions to address recommendations of the four DUEs completed during this reporting period.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication	**Current findings on previous recommendations:**

	variances ("MVR") consistent with generally accepted professional standards of care.	**Recommendation 1, June 2008:** Ensure that all MVRs are based on the written instructions regarding proper methods of reporting and investigating variances. **Findings:** PSH reported that the nursing coordinators of its programs currently review the MVRs prior to submission to the Therapeutics Review Committee to ensure that all sections of the reports are completed based on the written instructions. However, review by this monitor found that the current system of reporting and investigating the variances was not well aligned with the written instructions. **Recommendation 2, June 2008:** Continue review and analysis of medication variances and present summary of aggregated data to address the following: a. Total number of variances reported each month during the review period compared with numbers reported during the previous period; b. Classification of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of variances, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report). **Findings:** PSH presented data regarding medication variances that occurred during this review period. However, the data are not presented in this report because the facility recognized significant errors in data collection during this review period. Some of these errors involved

		duplications and/or misclassification of variances and/or problems with the computer software that tracks the variances. None of the reported variances had a severity outcome of category F (temporary harm to the individual and required initial or prolonged hospitalization) or higher. Only one variance required hospital intervention and intensive case analysis (ICA) was performed to address this variance. The ICA used contained appropriate conclusions and recommendations for corrective action. **Compliance:** Partial. **Current recommendation**: Report, review and analyze medication variances based on the current written instructions and present summary of aggregated data to address the following: a. Total number of variances reported each month during the review period compared with numbers reported during the previous period; b. Classification of variances by category (e.g. prescription, administration, documentation, etc) and by potential vs. actual; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of variances, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including	**Current findings on previous recommendation:**

	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.	**Recommendation, June 2008:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Compliance:** Partial. **Current recommendations**: Same as in F.1.a through F.1.h.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Compliance:** Partial. **Current recommendations**: Same as in F.1.a through F.1.h.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in F.1.b and F.1.f. to F.1.i.

		Findings: Same as in F.1.a through F.1.h. **Compliance:** Partial. **Current recommendations**: Same as in F.1.a through F.1.h.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, June 2008:** 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 D.1.b., D.1.c., D.1.f.viii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendation:** **Recommendation, June 2008:** 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. **Current recommendations**: Same as in D.1.b., D.1.c., D.1.f.viii and F.1.a through F.1.h.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed continuous anticholinergic treatment regardless of duration of treatment;	Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as F.1.e. **Findings:** Same as F.1.e. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in F.1.d. and F.1.g.

		Findings: Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in C.2.o and F.1.c. **Findings:** Same as in C.2.o and F.1.c. **Compliance:** Partial. **Current recommendations**: Same as in C.2.o and F.1.c.
F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** <u>Interviewed</u>: 1. Individuals EL and JM 2. Allison Pate, PhD, Senior Supervising Psychologist 3. David Haimson, PhD, Chief of Psychology 4. Dominique Kinney, PhD, Psychologist 5. Gari-Lyn Richardson, Director, Standards Compliance 6. George Christison, MD, Acting Chief of Psychiatry 7. Georgiana Vinson, RN 8. Helga Thordarson, PhD, Senior Supervising Psychologist 9. Melanie Byde, PhD, Mall Director 10. Melissa Avila, PT, By Choice Coordinator, Program 6 11. Steven Berman, PhD, Psychologist, By Choice Coordinator 12. Susan Velasquez, PhD, Coordinator, Psychology Specialized Services <u>Reviewed</u>: 1. Charts of the following 20 individuals: AH, AVD, CLB, DS, END, GEW, HR, JCS, JLB, JLW, JMS, KLK, KS, LDB, LH, MDB, PRS, SAR, VC, and WMM 2. The list of individuals who have utilized higher than threshold levels of seclusion, restraints, and psychiatric PRN or Stat medication for maladaptive behaviors in the last six months 3. Neuropsychological assessments completed in the last six months 4. Structural assessments completed in the last six months 5. Functional assessments completed in the last six months 6. Behavioral guidelines developed and implemented in the last six months 7. All PBS plans developed and implemented in the last six months 8. List of individuals reviewed by the Psychology Specialized Services Committee (May through October 2008) 9. List of individuals identified as needing neuropsychological services

		(May to October 2008) <u>Observed</u>: 1. WRPC for JC (Program 1, Unit 5) 2. WRPC for KDK (Program VI, Unit 71) 3. WRPC for MB (Program VI, Unit 71) 4. Pathways Intake To Orientation Mall Group 5. Court Preparation Mall Group 6. Stress Management Technique Mall Group 7. Fast Track PC 1370 Mall Group
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Compliance:** Partial.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to train all relevant staff on all aspects of PBS training. **Findings:** PBS team members at PSH have continued to improve their skills and competencies in PBS principles through ongoing training. One of the training sessions was conducted by the DMH CRIPA consultant, Dr. Nirbhay Singh. The PBS team members in turn have been conducting training on PBS principles with new employees, unit psychologists and the direct care staff.

		Compliance: Substantial. **Current recommendation**: Continue to train all relevant staff on all aspects of PBS training.
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By Choice" that encompasses self-determination and choice by the individuals served.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Report By Choice point allocation in the present status section of the individual's case formation and update at every scheduled WRPC. **Findings:** PSH is using the newly approved By Choice Manual. According to the By Choice Coordinator, the new guidelines have been distributed electronically to all clinical staff, team leaders and designated conference coordinators, and the By Choice Coordinator has been providing training on these new guidelines on an as-needed basis. In addition, the By Choice Coordinator also distributed examples on documenting point allocation changes in the WRPs to all clinicians and WRPT leaders. Using item 16 from the DMH Psychology Service Monitoring Form, PSH assessed its compliance based on an average sample of 10% of the WRPs due for the month (May to October 2008). The table below is a summary of the data: 16. *The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.* 26% 16.a *There is documentation that By Choice point allocation is updated monthly in the Present Status section of the case formulation in the individual's* N/A

	Wellness and Recovery Plan.	
16.b	*There is documentation that the individual determines the point allocation.*	N/A

	Previous period	Current period
Mean compliance rate		
16.	13%	26%
Compliance rate in last month of period		
16.	15%	21%
16.a	-	-
16.b	-	-

As the table above shows, WRPTs continue to have difficulty with proper point allocation documentation, despite the training received. According to the By Choice coordinator, sub-indicators 16.a and 16.b were not audited during this review period, but will be monitored at the next review period when the new PSH monitoring worksheet is implemented.

Only three (AH, AVD and DS) of the ten WRPs in the charts reviewed by this monitor (AH, AVD, DS, GEW, JCS, JMS, KS, LDB, PRS and VC) fulfilled the elements of this recommendation. In most of the WRPs, the documentation was not comprehensive, was not updated or the updates were merely repetitions from the previous WRP. Six of the WRPs (AH, AVD, DS, GEW, PRS and VC) contained documentation indicating that the individual participated in the point allocation process.

As plan of correction, PSH will train mentors who in turn will consult with WRPT members on addressing this requirement. The By Choice Coordinator will assist staff training new employees.

		Recommendation 2, June 2008: Ensure that the program receives adequate resources. **Findings:** According to the By Choice Coordinator, the program has received new equipment (e.g. coffee-maker, steps, safety ramp, refrigerator) for its new "coffee shop" in the Central-East compound, a computer for staff use, and "culture-specific" food items and cosmetics. PSH also secured a regular supply of donuts from its primary food vendor. According to the By Choice Coordinator, the program is seeking additional staff to perform audits, maintain continuity of services and conduct training. **Recommendation 3, June 2008:** Train all staff in correctly implementing the By Choice program. **Findings:** Information from the By Choice Coordinator and review of the training documentation found that 87% of the staff at PSH completed the By Choice "General" training, 66% the "Point Allocation" training, 14% the "Cycle Card" training, 6% "Data Entry" training, and 16% "Clinical" training. According to the By Choice Coordinator, some of the percentages are incorrect due to data collection errors. **Recommendation 4, June 2008:** Ensure that individuals know their performance requirements to earn full points. **Findings:** Using items 1-8 from the DMH By Choice Individual Satisfaction Survey Form (competed in October 2008), PSH assessed its compliance based on 409 individuals (a mean of 27% of the census during this review period, May to October 2008). The table below is a summary of the data:

1.	*Is the point system helpful to you?*	81%
2.	*Do staff explain how you earn an 'FP', 'MP', or 'NP' for all your activities?*	73%
3.	*Do staff tell you if you earned an "FP,'MP', or 'NP' for all your activities?*	60%
4.	*Are you satisfied with the numbers of points you can earn for each cycle or group?*	69%
5.	*Do you like what is offered in the incentive store?*	77%
6.	*Do you hold on to your point card during the day?*	80%
7.	*Do you discuss how you want your points allocated when you meet with your team during your conferences?*	80%
8.	*Is there an item or activity that you would like offered in the incentive stores?*	47%

As the table above shows, individual satisfaction with the By Choice program is fairly high (mean percentage of items 1-7 is over 70%). The compliance rate specific to Recommendation 4 is 73% (item 2 in the table). It is not possible to make a meaningful comparison of the data with the previous review period as the questions have changed and the same individuals were not surveyed (due to new admissions and discharges).

As plan of correction: PSH plans to post performance criteria to earn points in public locations at each unit, as well as attach a one-page description of the performance criteria to the inside of the Mall roster folders. The By Choice coordinator will speak with the Central Council President to encourage unit representatives during CRG meetings to remind individuals to request reallocation of their points during their WRPCs.

PSH also assessed individuals' By Choice competency using items 1-10

from the DMH By Choice Competency and Fidelity Survey-Individual Form, based on a mean sample of 4% of the individuals in PSH for each month (May to October 2008). The table below is a summary of the data (this monitor modified PSH's table by leaving out the sub-indicators; the indicators reflect the mean scores of the sub-indicators):

1.	*The individual is holding his/her own point card.*	92%
2.	*The individual states, to the best of his/her ability how points are earned.*	97%
3.	*The individual states, to the best of his/her ability how points are spent.*	94%
4.	*The individual states, to the best of their ability, the expectations for earning FP, MP, or NP for the current cycle.*	90%
5.	*The individual states, to the best of their ability, the possible number of points that may be earned each day.*	83%
6.	*The individual states, to the best of their ability, how the points are reallocated for their point card.*	49%
7.	*The individual states, to the best of their ability, the hours the incentive store is open.*	90%
8.	*The individual states, to the best of their ability, the cycles of "high priority" on their point card.*	49%

As the table shows, the individuals surveyed have a good understanding of the By Choice plan. The area that needs significant improvement is their understanding of point re-allocation. This deficit is also reflected in the low compliance with WRP documentation of By Choice point allocation. There is a strong correlation between the individuals' poor understanding of the By Choice point re-allocation and the weak documentation of By Choice point allocation in the Present Status section of the individuals' WRPs.

PSH also assessed staff By Choice competency, using items 1-10 from the DMH By Choice Competency and Fidelity Survey-Staff Form, based on a mean sample of 8% of the AM/PM Nursing staff for each month (May to October 2008). The table below is a summary of the data (this monitor modified PSH's table by leaving out the sub-indicators; the indicators reflect the mean scores of the sub-indicators):

1.	*Staff correctly states the current point cycle.*	69%
2.	*Staff correctly states the procedures for assigning participation levels on point cards.*	86%
3.	*Staff correctly states the criteria for assigning FP, MP, and NP for the current cycle.*	94%
4.	*Staff correctly assigns a participation level and marks and individual's card per the By Choice Manual.*	87%
5.	*Staff locates the By Choice Manual.*	90%
6.	*Staff can correctly state the difference between a 'baseline' point card and a 'reallocated' point card.*	66%
7.	*Staff correctly states where the point reallocation documentation is located.*	78%
8.	*Staff can locate a current By Choice Manual in their work site.*	97%
9.	*There is a system to orient new individuals to the By Choice Incentive System.*	77%
10.	*Staff is able to state their unit's incentive store hours of operation.*	83%

As the table above shows, staff competency needs improvement in certain areas, especially in their understanding of the point cycle and the difference between the "baseline" and "reallocated" point card.

As plan of correction, PSH plans to continue to train and mentor facilitators in all areas of the By Choice program, with emphasis to

items that received low scores.

PSH also assessed the Incentive Store operation and the Incentive Store staff competency, using items 1-10 from the DMH By Choice Competency and Fidelity Survey-Incentive Store Form (from May to October 2008). The table below is a summary of the data:

1.	*The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Mall Offices/Area.*	58%
1.a	*The incentive store has regular hours of operation.*	100%
1.b	*Hours are posted in all stores, units, and Mall areas.*	58%
2.	*The incentive store includes a delivery system that ensures that all individuals have access to incentive items.*	100%
3.	*The incentive store is well stocked with appropriate items from the incentive list.*	94%
4.	*The incentive store has an inventory control system.*	81%
5.	*The incentive store has a system to track and remove outdated food items.*	85%
6.	*There is a By Choice Manual located in the incentive store.*	92%
7.	*The incentive store staff has completed incentive store training.*	100%
8.	*The individuals bring their point cards to the store to make a purchase.*	55%
9.	*There is a By Choice Calorie Activity Guide located in the incentive store.*	51%
10.	*There is an Alert in the incentive store, for staff reference.*	75%

As the table above indicates, a number of areas need improvement,

		especially in regard to having alerts in all incentive stores for staff reference. This is important to ensure that incentive store staff does not deliver unsafe food items to individuals. The data for item 1.a is suspect given that the information from the By Choice Coordinator indicated otherwise (i.e. in some cases store hours are not fixed). According to the By Choice Coordinator, at times staff is assigned other duties by their respective programs, forcing store closures at "unpredictable" times. As plan of correction, PSH plans to post incentive store hours in all stores, units, and Mall areas; establish an inventory control system and ensure removal of outdated food items; ensure that the Calorie Activity Guides are located in the incentive store; post an Alert in the incentive store for staff reference; and improve data reliability. **Compliance:** Partial. **Current recommendations**: 1. Report By Choice point allocation in the present status section of the individual's case formation and update at every scheduled WRPC. 2. Ensure that the program receives adequate resources. 3. Train all staff in correctly implementing the By Choice program. 4. Ensure that individuals know their performance requirements to earn full points.
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice.

		Findings: The Chief of Psychology continues to have all clinical and administrative authority for the PBS teams and the By Choice incentive program. However, the Chief of Psychology has chosen to share some of the responsibility with the Coordinator of Psychology Specialty Services. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Partial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice of staff training on PBS principles and practices. **Findings:** PBS team members have continued to receive training on PBS principles and practices. Using item 5 from the DMH Psychology Service Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the PBS plans implemented in the review month (May to October 2008). The table below is a summary of the data: 5. *PBS assessments include structural and functional assessments, and as necessary, functional analysis* 100% 5.a *Pertinent records were reviewed (e.g., individual's* 100%

	chart/record, meeting notes, anecdotal records, evaluations, previous interventions),	
5.b	*Structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were conducted, as needed, to determine broader variables affecting the individual's behavior,*	100%
5.c	*Functional assessment interviews were conducted with people (e.g., individual, parents and family members, therapists and care staff, teachers) who often interact with the individual within different settings and activities, as needed.*	100%
5.d	*Direct observations were conducted across relevant circumstances (e.g., multiple settings, over time) and by more than one observer, as appropriate,*	100%
5.e	*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, as needed, and*	100%
5.f	*If necessary, suspected maintaining variables were manipulated to assess the motivation(s) for the individual's behavior.*	100%

This monitor's findings from review of all the PBS plans implemented during this review period (KLK, LH, MLB and VC) found that all PBS plans were developed from data derived from structural and functional assessments.

Current recommendation:
Continue current practice of staff training on PBS principles and practices.

F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Ensure that proper assessments are conducted prior to developing and implementing intervention plans. • Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation. **Findings:** Using item 6 from the DMH Psychology Service Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the PBS plans implemented in the review month (May to October 2008). The table below is a summary of the data: 6. *Hypotheses of the maladaptive behavior are based on structural and functional assessments* 100% 6.a *There is at least one written hypothesis of the functions of the behavior, and* 100% 6.b *The hypothesis is aligned with findings based on structural and/or functional assessments* 100% This monitor's findings from review of all the PBS plans implemented during this review period (KLK, LH, MLB and VC) are in agreement with the facility's data. However, in many cases the language in the interventions section was vague, verbose, and read like information that is better included in the assessment sections. The interventions should be precise and written in active voice telling what the person responsible to implement the plan should be doing. **Current recommendations**: 1. Ensure that proper assessments are conducted prior to developing

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<tr><td></td><td></td><td>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.</td></tr>
<tr><td>F.2.c.iii</td><td>There is documentation of previous behavioral interventions and their effects;</td><td>Current findings on previous recommendation:

Recommendation, June 2008:
Continue current practice.

Findings:
Using item 7 from the DMH Psychology Service Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the PBS assessments conducted in the review month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>7.</td><td>There is documentation of previous behavioral interventions and their effects</td><td>100%</td></tr>
<tr><td>7.a</td><td>There is documentation of previous behavioral interventions, and</td><td>100%</td></tr>
<tr><td>7.b</td><td>The effects of these interventions.</td><td>100%</td></tr>
</table>

This monitor's findings from review of all the PBS plans implemented during the period (KLK, LH, MLB and VC) are in agreement with the facility's data.

Current recommendation:
Continue current practice.</td></tr>
<tr><td>F.2.c.iv</td><td>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</td><td>Current findings on previous recommendation:

Recommendation, June 2008:
Ensure that all behavioral interventions are based on a PBS model</td></tr>
</table>

<table>
<tr>
<td></td>
<td>contingencies;</td>
<td>without any use of aversive or punishment contingencies.

Findings:
Using item 8 from the DMH Psychology Service Monitoring Form, PSH assessed its compliance based on an average sample of 89% of the behavior interventions implemented in the review month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>8.</td><td>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</td><td>95%</td></tr>
</table>

The mean compliance rate was 99% in the previous review period.

This monitor's review of all PBS plans developed and implemented during this review period (KLK, LH, MLB and VC) found them to be following the positive behavior supports model without any use of aversive or punishment contingencies. However, a couple of behavior guidelines had included restrictive procedures. The Senior Psychologists had reviewed the behavior guidelines and removed the restrictive procedures. PBS teams should ensure that unit psychologists are trained to recognize restrictive procedures.

Current recommendation:
Ensure that all behavioral interventions are based on a PBS model without any use of aversive or punishment contingencies.</td>
</tr>
<tr>
<td>F.2.c.v</td>
<td>behavioral interventions are consistently implemented across all settings, including school settings;</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, June 2008:
• Conduct training across settings so that staff in those settings has the knowledge and skill to implement interventions for individuals</td>
</tr>
</table>

who are on such plans.

- Monitor the implementation of PBS plans to ensure that all behavioral interventions are consistently implemented across all settings, including the PSR Mall and vocational and education settings.

Findings:
Using item 9 from the DMH Psychology Service Monitoring Form-PBS Plans, PSH assessed its compliance based on an average sample of 100% of the PBS plans implemented in the review month (May to October 2008). The table below is a summary of the data:

9.	*Behavioral interventions are consistently implemented across all settings, including school settings*	33%

Comparative data showed a decline in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
9.	100%	33%
Compliance rate in last month of period		
9.	100%	68%

According to the PBS team members and the Chief of Psychology, two of the three plans were poorly implemented due to poor cooperation from the WRPT members.

This monitor's findings from review of the three PBS plans (KLK, LH and VC) are in agreement with the facility's data.

As plan for correction, the PBS teams will continue to work with the

WRPTs to implement the PBS plans. The PSSC Coordinator will address the issue of implementation as part of the Risk Management System during the PSSC meetings.

PSH also audited the behavior guidelines for this recommendation. Using item 9 from the DMH Psychology Service Monitoring Form-Behavior Guidelines, PSH assessed its compliance based on an average sample of 79% of the behavior guidelines implemented in the review month (May to October 2008). The table below is a summary of the data:

9.	*Behavioral interventions are consistently implemented across all settings, including school settings*	70%

Comparison not possible as data for behavior guidelines were not presented during the previous review period.

As plan for correction, the PSSC Coordinator is to gather and share data with Unit Psychologists, Unit Supervisors, and Program management during the PSSC meetings. PBS team members are to assist WRPTs in implementing the behavior guidelines.

The PBS and Behavior Guideline trainers need to emphasize developing function-based interventions. Many of the behavioral interventions are generic, are similar across plans and lack data on replacement behaviors, and prevention strategies are not aligned with the stated functions.

Current recommendations:

1. 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.
2. Monitor the implementation of PBS plans to ensure that all

<table>
<tr><td></td><td></td><td>behavioral interventions are consistently implemented across all settings, including the PSR Mall and vocational and education settings.</td></tr>
<tr><td>F.2.c.vi</td><td>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;</td><td>

Current findings on previous recommendation:

Recommendation, June 2008:
Ensure proper documentation.

Findings:
PSH has an established trigger threshold review criteria. When individuals trigger, the information is shared with the Chief of Psychology and PBS staff. The PBS teams review the trigger data and determine if a behavioral intervention is warranted. Trigger data is also reviewed at the Psychology Specialty Service meetings.

Using item 10 from the DMH Psychology Service Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the individuals who triggered in the review month (May to October 2008). The table below is a summary of the data:

<table>
<tr><td>10.</td><td>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</td><td></td></tr>
<tr><td>10.a</td><td>A referral has been made to the Coordinator of Psychology Specialist Services, and</td><td>33%</td></tr>
<tr><td>10.b</td><td>Appropriate assessment and/or interventions have been initiated</td><td>4%</td></tr>
</table>

As the data in the table above show, a large number of individuals who trigger are not always referred for review and assessment and where
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		appropriate, follow-through with a behavioral intervention. This monitor's review of findings from the trigger data is in agreement with the facility's data. **Current recommendation**: Ensure and document that individuals who trigger are referred for assessment and where appropriate, behavioral intervention(s).
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that treatment modalities are integrated to better serve individuals, as indicated. **Findings:** Using item 11 from the DMH Psychology Service Monitoring Form-PBS plans, PSH assessed its compliance based on an average sample of 100% of the PBS plans due for the month (May to October 2008). The table below is a summary of the data:

11.	*Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.*	0%
11.a	*Initial consultation between the PBS psychologist and the WRPT psychiatrist and psychologist regarding specific pharmacological and behavioral interventions to be used for managing the individual's psychiatric illness and learned maladaptive behavior.*	50%
11.b	*Joint review of the following by the PBS psychologist with the WRPT psychiatrist and psychologist:*	

11.b.i	*Review of PBS plans prior to implementation*	75%
11.b. ii	*Review of individual's progress in behavioral treatment*	50%
11.b. iii	*Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment, and*	0%
11.b. iv	*Modification, as clinically appropriate, of diagnosis and/or pharmacological and/or treatment based on above reviews/assessments.*	0%

Review of information found that psychologists are in discussion with psychiatrists, as evidenced by psychology notes, but are not using the information in a formal way, integrating the information into the assessments and/or the intervention plans.

The compliance for both this and the previous review period was similar, very low.

The findings from this monitor's review of three PBS plans (KLK, LH and VC) were in agreement with the facility's data.

PSH also audited the behavior guidelines for this requirement. Using item 11 from the DMH Psychology Service Monitoring Form-Behavior Guidelines, PSH assessed its compliance based on an average sample of 79% of the behavior guidelines due for the month (May to October 2008). The table below is a summary of the data:

11.	*Psychologists writing the behavior guideline and team psychiatrists integrate their therapies with other treatment modalities, including drug therapy.*	0%
11.a	*Initial consultation between the unit psychologists and the WRPT psychiatrist and psychologist*	9%

	regarding specific pharmacological and behavioral interventions to be used for managing the individual's psychiatric illness and learned maladaptive behavior.	
11.b	*Joint review of the following by the unit psychologist with the WRPT psychiatrist and psychologist:*	0%
11.b.i	*Review of the behavior guidelines prior to implementation*	4%
11.b. ii	*Review of individual's progress in behavioral treatment*	4%
11.b. iii	*Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment, and*	0%
11.b. iv	*Modification, as clinically appropriate, of diagnosis and/or pharmacological and/or treatment based on above reviews/assessments.*	0%

No comparison data is available as audit for behavior guidelines was not conducted for the previous review period.

This monitor reviewed five behavior guidelines (CLB, END, JLW, MDB and SAR). None of them had integrated their therapies with other modalities.

As plan of correction: PBS chairs are to ensure that all interdisciplinary collaboration information is integrated into the assessments and intervention plans, and is documented in the individuals' WRPs. In the case of the behavior guidelines, the Senior Psychologist, WRPT psychologist and psychiatrist are to collaborate to comply with this recommendation. Also, the Coordinator of Psychology Specialist Services is to model the consultation process with the WRPT

		Psychologist and Psychiatrist and document the consultation. **Current recommendation:** Ensure that treatment modalities are integrated to better serve individuals, as indicated.
F.2.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 recommendation:** **Recommendation, June 2008:** Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual. **Findings:** Using item 16 from the DMH Psychology Service Monitoring Form-PBS plans, PSH assessed its compliance based on an average sample of 100% of the PBS plans due for the month (May to October 2008). The table below is a summary of the data: 12. *All positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan* — 0% 12.a *There is an objective in the WRP that specifies in behavioral, observable and/or measurable terms that the individual will learn alternative ways of behaving, and* — 33% 12.b *There are at least two interventions in the WRP aligned with the Objective, one of which is an active treatment and refers to a Behavior Guideline or PBS plan and the other is a reference to the implementation of the Behavior Guideline or PBS plan in the therapeutic milieu.* — 0% Comparative data showed a decline in compliance since the last review

as follows:

	Previous period	Current period
Mean compliance rate		
12.	46%	0%
Compliance rate in last month of period		
12.	50%	0%

This monitor reviewed the PBS plans audited by PSH, and the monitors findings are in agreement with the facility's data.

PSH also audited the behavior guidelines to address this recommendation. Using item 12 from the DMH Psychology Service Monitoring Form-Behavior Guidelines, PSH assessed its compliance based on an average sample of 79% of the behavior guidelines due for the month (May to October 2008). The table below is a summary of the data:

12.	*All behavior guidelines are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan*	0%
12.a	*There is an Objective in the WRP that specifies in behavioral, observable and/or measurable terms that the individual will learn alternative ways of behaving, and*	11%
12.b	*There are at least two interventions in the WRP aligned with the Objective, one of which is an active treatment and refers to a Behavior Guideline and the other is a reference to the implementation of the Behavior Guideline in the therapeutic milieu.*	3%

Behavior guidelines were not previously audited relative to this

		requirement, so there is no data for comparison. This monitor reviewed five behavior guidelines (CLB, END, JLW, MDB and SAR). Only SAR had a foci and intervention related to the behavior guideline. The remaining four did not. As plan of correction, PSH will have the PBS chair attend WRPCs to assist in documenting and updating outcome data in the Present Status section of the individual's WRP. The PSSC Coordinator will train unit psychologists on this new requirement. Outcome data on PBS plans and behavior guidelines will be tracked by the PSSC Coordinator. **Current recommendation**: Specify PBS plans in the objectives and interventions sections of the individual's WRP, as outlined in the DMH WRP Manual.
F.2.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:** **Recommendations 1 and 2, June 2008:** • Collect objective information to evaluate the effectiveness of the PBS plans, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change. • Continue to track and monitor that PBS plans are updated using outcome data in the individual's present status section of the WRP. **Findings:** Using item 13 from the DMH Psychology Services Monitoring Form-PBS plans, PSH assessed its compliance based on an average sample of 100% of the PBS plans for each month (May to October 2008). The table below is a summary of the data: 13. *All positive behavior support plans are updated as* 18%

	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	
13.a	*There are quantitative outcome data for the plan,*	18%
13.b	*The outcome data are documented monthly in the Present Status section of the case formulation of the individual's WRP, and*	27%
13.c	*The Behavior Guidelines and PBS plans are updated, as indicated by the outcome data*	18%

Comparative data showed a decline in compliance since the last review as follows:

	Previous period	Current period
Mean compliance rate		
13.	80%	18%
Compliance rate in last month of period		
13.	50%	0%

Review of information found that the PBS teams had difficulty getting unit staff cooperation (in two of the three PBS plans developed and implemented during this review period) in implementing the PBS plans and collecting the relevant data.

PSH also audited the behavior guidelines developed and implemented during this review period, using item 13 from the DMH Psychology Services Monitoring Form-Behavior Guidelines, PSH assessed its compliance based on a sample of 79% of the Behavior Guidelines developed and implemented for each month (May to October 2008). The table below is a summary of the data:

13.	*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*	0%
13.a	*There are quantitative outcome data for the plan,*	68%
13.b	*The outcome data are documented monthly in the Present Status section of the case formulation of the individual's WRP, and*	11%
13.c	*The Behavior Guidelines and PBS plans are updated, as indicated by the outcome data*	22%

As the table above shows, documentation related to behavior guidelines in the Present Status section of the individuals' WRPs is poor. Comparison data were not available as documentation of behavior guidelines in the Present Status section of the WRP was not tracked in the past.

This monitor reviewed charts of four individuals with a PBS plan (KLK, LH, MLB and VC). There was good documentation of the plan with quantitative data for MLB in the Present Status section of the WRP. Documentation for LH and VC was not comprehensive. In the case of KLK, there was documentation indicating that there was difficulty obtaining data because the plan was not fully implemented.

A review of the charts of eight individuals with behavior guidelines (CLB, END, HR, JLB, JLW, MDB, SAR and WMM) found good documentation in five of them (CLB, HR, JLW, SAR and WMM).

The facility's plan of correction is the same as that outlined in F.2.c.viii.

Current recommendations:

1. Collect objective information to evaluate the effectiveness of the

		PBS plans and behavior guidelines, including change in behaviors, stability of behavior change, changes in co-varying behaviors, achievement of broader goals and durability of behavior change. 2. Continue to track and monitor that PBS plans and behavior guidelines are updated using outcome data in the individual's present status section of the WRP.
F.2.c.x	all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Provide competency-based PBS training to all staff. • 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:** According to the Chief of Psychology and the Coordinator of PSSC, the PBS teams have encountered resistance from some unit staff to implement PBS plans. This has affected the individual concerned and defeated the efforts of the PBS team members. Using item 14 from the DMH Psychology Services Monitoring Form, PSH assessed its compliance using a sample of 100% of the PBS plans implemented for each month (May to October 2008). The table below is a summary of the data:

14.	*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.*	0%
14.a	*There is a list of certified staff trained to implement the PBS plan,*	100%
14.b	*There is a training database with details of the*	73%

	training and competency scores for the certified staff,	
14.c	*Staff not reaching competency standards have been retrained until competency is reached before they implement the PBS plan, and*	55%
14.d	*There is monthly fidelity of implementation or behavioral rehearsal data on each PBS plan.*	0%

As shown in the table above, staff participation in training on behavior intervention plans is poor. The PBS teams need the support of the senior management to ensure that unit staff and WRPTs take seriously PBS plans/behavior interventions, especially regarding implementation of PBS plans with maximum fidelity.

As plan of correction, the PSS Coordinator will use the Risk Management System when encountering staff resistance to full implementation of behavior intervention plans, and present data to the Program Management for their support.

Current recommendations:
1. Provide competency-based PBS training to all staff.
2. 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.

F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure required number of PBS teams to meet the 1:300 ratio. **Findings:** PSH does not have a sufficient number of PBS teams to meet the 1:300 ratio. PSH has added only two PBS team members (RNs) since the last review. PSH is recruiting to fill the vacant positions. However, it

<table>
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<td>appears a number of positions will not be filled because there is no allocation for these positions (for example, Psychiatric Technician and Data Analyst). According to the Chief of Psychology, all existing PBS team members primarily perform duties relevant to the provision of behavioral interventions and PSR Mall groups. When a PBS team member is required to do mandatory overtime (for example State holidays) they are usually assigned to tasks aligned with PBS duties.

Current recommendation:
Ensure required number of PBS teams to meet the 1:300 ratio.</td>
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<tr>
<td>F.2.c.xii</td>
<td>the By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan.</td>
<td>Current findings on previous recommendation:

Recommendation, June 2008:
Ensure that By Choice point allocation is updated monthly in the individual's WRP.

Findings:
PSH assessed its compliance with this item using item 16 from the DMH Psychology Services Monitoring Form, based on a 10% sample of the WRPs due each month (May to October 2008). The table below showing the indicators and sub-indicators is a summary of the data (PSH did not audit the sub-items).
<table>
<tr><td>16.</td><td>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</td><td>26%</td></tr>
<tr><td>16.a</td><td>There is documentation that By Choice point allocation is updated monthly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</td><td>N/A</td></tr>
<tr><td>16.b</td><td>There is documentation that the individual determines the point allocation</td><td>N/A</td></tr>
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		Comparative data showed modest improvement over the previous review period of 13%. This monitor reviewed nine charts (AVD, DS, GEW, JCS, JMS, KS, LDB, PRS and VC). Two of the WRPs in the charts (AVD and DS) had proper updates of the By Choice documentation, and the remaining seven (GEW, JCS, JMS, KS, LDB, PRS and VC) did not. In a number of cases the "updates" were mere transfers from the previous WRP. **Current recommendation**: Ensure that By Choice point allocation is updated monthly in the individual's WRP.
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT); consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.	**Current findings on previous recommendations:** **Recommendations 1-5, June 2008:** • Develop and implement a full DCAT, consisting of a clinical psychologist, registered nurse, social worker, psychiatric technician, and data analyst. • Ensure that all individuals with cognitive challenges are assessed by the DCAT. • Ensure that all DCAT members are available for consultation to other staff to assist with planning therapeutic activities at the individual's cognitive functioning level. • Ensure that DCAT members' primary responsibility is consistent with the EP. • Ensure that DCAT members receive appropriate training. **Findings:** PSH has yet to deploy a full DCAT. According to the Chief of Psychology, PSH has hired a DCAT chair and a Psychiatric Technician. An interview had been conducted for the Social Worker position. Apparently, according to the Chief of Psychology, the Registered Nurse

		and the Data Analyst positions were not allocated. This is surprising given that the other State facilities have these positions allocated. The newly hired DCAT members are still under training. Meanwhile, the psychology and NCS staff has taken on some of the DCAT responsibilities. For example, cognitive screening is done during the Integrated Assessment: Psychology section; DCAT/PBS referrals are handled by the existing PBS teams; and cognitive assessments are conducted by the Neuropsychology Consultation Service. **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 individual's cognitive functioning level. 4. Ensure that DCAT members' primary responsibility is consistent with the EP. 5. Ensure that DCAT members receive appropriate training.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this	**Current findings on previous recommendation:** **Recommendation, June 2008:** Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. **Findings:** PSH has integrated the BCC staff and process into the newly

	committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.	established Psychology Specialist Services Committee (PSSC). This monitor attended one of the PSSC meetings. The meeting was well-attended and the activities during the meeting were organized and comprehensive. A review of the PSSC meeting minutes found that the PSSC had reviewed a significant number of cases during this review period, especially individuals with triggers involving restraint, seclusion and self-harm. The PSSC reviewed as many as 88 cases in May, 65 in June, 57 in July, 38 in August, 64 in September, and 89 in October 2008. As part of the PSSC review, 28 behavior guidelines were written and implemented. Overall, PSH had implemented 72 behavioral plans (68 behavior guidelines, and four PBS plans). PSSC now receives referrals through the Risk Management System for behavior control of individuals on PRN and Stat medications. This monitor discussed with the PSSC Coordinator and the Chief of Psychology the need to refine the process in order to not let high-risk cases fall through by waiting for them to meet the threshold (at times, low-frequency severe/intense behaviors need attention), and for the team to determine cases that needed to enter the PBS pathway and not always follow the behavior guideline-PBS route. Both the staff are aware of this need but await staffing increase to meet some of these goals. **Compliance:** Substantial. **Current recommendation**: Schedule regular meetings and ensure that all standing members of the PSSC attend the meetings regularly.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological	**Current findings on previous recommendations:**

	assessment of individuals with persistent mental illness.	**Recommendation 1, June 2008:** Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments. **Findings:** According to the Chief of Psychology and the Neuropsychologist, Dominique Kenney, referrals are being made when appropriate for neuropsychological assessments. The number of referrals has increased slightly from 78 for the previous review period to 81 during this review period. PSH has been training staff on making appropriate referrals. In May 2008, the Neuropsychology Consultation Service (NCS) trained newly hired psychologists; in August, 2008, NCS entered information in PSH's "Psychiatrist Handbook" on making referrals for neuropsychological assessments; and in September 2008, NCS trained newly hired psychologists and psychology trainees. As plan of improvement, PSH will continue to train clinicians, work with the Risk Management system, and encourage the Senior Psychologists to work with the WRPTs for making appropriate referrals. **Recommendations 2 and 3, June 2008:** • Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services. • Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion. **Findings:** PSH had four neuropsychologists during the previous review period. That number is consistent. PSH requires additional neuropsychologists to complete all assessments in a timely fashion and provide other relevant services, including PSR Mall services. The NCS staff was involved in completion of the cognitive screening portion of IAPs to identify individuals requiring further neuropsychological assessments,

which further affected what and how much the neuropsychologists could achieve during this review period.

Using item 18 from the DMH Psychology Services Monitoring Form, PSH assessed its compliance regarding completion of neuropsychology referrals received during this review period (May to October 2008) in a timely fashion. The table below is a summary of the data:

		Mean
18.a.i	*Number of neuropsychological assessments due for completion in the review month*	14.6
18.a.ii	*Of those in 18.a.i, number completed*	2.6
18.a.iii	*Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period*	83.5 days

As the table above shows, an average of 15 assessments were due per month. PSH was only able to complete an average of three assessments per month. It took PSH an average of 84 days to complete an assessment from the day a referral was made (the criteria to complete a referral is a calendar month). The Chief of Psychology pointed out that it took an average of 30 days to complete an assessment once the assessment was initiated, except for the assessments conducted by trainees which took a little longer to complete.

PSH completed 59 assessments during this review period, an improvement over the 30 assessments completed during the previous review period. PSH has 24 referrals on the waiting list as of October 31, 2008, and this number is lower than the wait list number of 36 during the previous review period.

As plan of correction, PSH will increase the number of neuropsycholo-

		gists on its staff, reduce the number of referrals on the waiting list and complete new referrals in a timely manner. PSH will also continue to participate in the Psychology Internship and Postdoctoral Trainee programs and have trainees participate in the neuropsychological assessment services. **Compliance:** Partial. **Current recommendations**: 1. Ensure that WRPT members, especially psychiatrists and psychologists, make referrals, when appropriate, for neuropsychological assessments. 2. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services. 3. Ensure that retesting and follow-up neuropsychological evaluations are conducted in a timely fashion
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** All psychologists at PSH have received 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 (AD 15.09, 9/12/07). According to the Chief of Psychology, the Medical Executive Committee has granted its approval. At this time, the Coordinator of Specialty Services is working with the Coordinator of Nursing to define Nursing response to these orders.

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

3. Nursing Services		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Charles Allen, Nursing Coordinator, Program VI 2. Diana Jean Walayat, RN 3. George Fedorka, RN, Admission Suite 4. Gwendeline Init, RN 5. James Jordan, Unit Supervisor, Admission Suite 6. Kathy Wood, Nursing Coordinator, Program VI 7. Lidia Lau, Assistant Coordinator of Nursing Services 8. Regina Olender, Nurse Administrator 9. Tatiana Rojas, RN Auditor 10. Tu Lim, RN, Admission Suite Reviewed: 1. PSH's progress report and data 2. Enhancement Plan of Action Tracking Sheet 3. Nursing Services and the Enhancement Plan Progress quarterly reports 4. Shift Lead Meeting minutes dated 8/2/08 5. PSH training rosters for PRN and Stat Medication Training; Medication Variance Training; WRP Foci and Objectives Training; WRP Interventions and Mall Integration Module; WRP Level 1 Training; Provision of Medical Care; Principles of Medication; Recovery-Based Mental Health Nursing; Therapeutic Relations; Positive Behavior Support (PBS) Training; 6. SO 902.02, Therapeutic Strategies and Interventions 7. Change in Physical Status Note form 8. Nursing Transfer Note form 9. Medication Pass Process 10. Medication Treatment Records (MTRs) and Control Sheets for Units 20, 21, 22, 24, 25, 26, and 27

		11. Medical records for the following 37 individuals: AH, AKR, BRA, CB, CLB, DAL, DBP, DLR, DLS, GWA, HLE, HR, JAA, JG, JW, KAF, KBS, KLA, KLK, KW, LAB, LD, MDG, MLB, NCC, ND, NPT, RTH, SA, SDH, SEJ, SLK, TEL, VLM, VMC, VN and WMM Observed: 1. 7 a.m. medication administration on Units 30 and 31 2. MedSelect system 3. Shift report on Unit EB-01 4. WRPC on Program IV, Unit 36 5. WRPC on Program VI, Unit EB-09
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Increase sample size for PRN and Stat data. **Findings:** The mean sample size 21% for Stat data, but only 15% for PRN data. **Recommendation 2, June 2008:** Ensure reliability of PRN/Stat data. **Findings:** No data was provided addressing this recommendation.

Recommendation 3, June 2008:
Continue to monitor this requirement.

Findings:
PSH's compliance data from the DMH Nursing Services Monitoring PRN audit, based on an average sample of 15% of PRNs administered each month (May-October 2008), indicated the following:

1.	*Safe administration of PRN medications*	94%
1.a	*PRN medication was administered based on a complete physician's order*	99%
1.b	*The nurse administered correct medication, dose, form and route, on the correct date, and for correct indication to the correct individual*	94%

PSH's compliance data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 21% of Stats administered each month (May-October 2008), indicated the following:

1.	*Safe administration of Stat medications*	89%
1.a	*Stat medication was administered based on a complete physician's order*	100%
1.b	*The nurse administered correct medication, dose, form, and route, on the correct date, and for correct indication to the correct individual*	90%

The table below represents PSH's Stat comparison data:

	Previous period	Current period
Mean compliance rate		
1.	84%	89%

Compliance rate in last month of period		
1.	84%	89%
1.a	92%	100%
1.b	84%	89%

PSH indicated that staff was in need of training and that the Nurse Administrator would identify staff in need of training.

A review of 100 PRNs and Stat medications orders for 30 individuals (AH, AKR, BRA, CB, CLB, DAL, DBP, DLR, GWA, HLE, JAA, JG, JW, KAF, KBS, KLA, KLK, LD, MDG, MLB, NCC, RTH, SA, SDH, SEJ, SLK, TEL, VLM, VMC and WMM) found that 72 orders did not specify individual behaviors. In addition, 69 incidents noted in the IDNs did not include either the correct notation of Stat or PRN, the name of the medication administered, the dosage administered, the route given, or an IDN documenting that the PRN or Stat medication was given.

From observations of 7 a.m. medication administration on Units 30 and 31, this reviewer noted that one medication was pre-signed on the MTR prior to administration. In addition, one medication nurse had not been given any training regarding the MedSelect system prior to using it. It was also reported that medications are not consistently given within the appropriate time frames due to the large number of individuals who receive morning medications and to problematic issues related to the MedSelect system. In addition, a number of staff stated that they frequently had to have another nurse access the system, which would not accurately reflect the staff who actually administered the medications. Also, there was very little medication education provided.

Current recommendations:

1. Ensure accuracy of documentation regarding medication administration and the MedSelect system.
2. Continue to monitor this requirement.

F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendation:** **Recommendation, June 2008:** See F.3.a.i. **Findings:** PSH's compliance data from the DMH Nursing Services Monitoring PRN audit, based on an average sample of 15% of PRNs administered each month (May-October 2008), indicated the following:

2.	*Documentation of all the circumstances requiring PRN administration of medication.*	62%
2a.	*In the MTR, there is a brief description of the circumstances and behavior requiring PRN medication.*	79%
2b.	*In the IDN, there is a comprehensive assessment of the individual prior to the PRN medication.*	77%

PSH's PRN comparison data demonstrate variability and are outlined below:

	Previous period	Current period
Mean compliance rate		
2.	55%	62%
Compliance rate in last month of period		
2.	57%	53%
2.a	72%	76%
2.b	81%	69%

PSH indicated that there has been some misinterpretation by the nursing staff regarding the documentation requirements, which accounts for the variability in compliance rates. The facility has

implemented tracking of the specific nursing staff giving PRN/Stat medications to review the results of the audit. In addition, PSH has included PRN and Stat medication requirements in the Principles of Medication class for new and existing staff. As of 10/28/08, training compliance for the PRN and Stat Medication requirements was reported at 91%, an increase from 79% in May 2008.

A review of 50 incidents of PRN medications for 15 individuals (AKR, BRA, CB, CLB, DBP, DLR, JAA, KAF, KBS, LD, NCC, RTH, SA, SLK and VMC) found that 34 incidents included the documentation of circumstances requiring the PRN in the IDNs.

PSH's compliance data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 21% of Stats administered each month (May-October 2008), indicated the following:

2.	*Documentation of all the circumstances requiring Stat administration of medication.*	63%
2.a	*In the MTR, there is a brief description of the circumstances and behavior requiring Stat medication.*	72%
2.b	*In the IDN, there is a comprehensive assessment of the individual prior to the Stat medication.*	85%

PSH's comparison data for Stat medications demonstrated variability as noted below:

	Previous period	Current period
Mean compliance rate		
2.	57%	63%

		<table><tr><td colspan="3">Compliance rate in last month of period</td></tr><tr><td>2.</td><td>68%</td><td>59%</td></tr><tr><td>2.a</td><td>76%</td><td>68%</td></tr><tr><td>2.b</td><td>88%</td><td>80%</td></tr></table> PSH indicated that barriers to compliance included that when the order states "for agitation," the nursing staff usually writes that administration was "for agitation." Also, if signatures are noted to be illegible, the item is scored as noncompliant. PSH's plan of correction is noted above in the PRN section. A review of 50 incidents of Stat medications for 15 individuals (AH, DAL, GWA, HLE, JG, JW, KLA, KLK, MDG, MLB, SDH, SEJ, TEL, VLM and WMM) found that 39 incidents included the documentation of circumstances requiring the Stat medication in the IDNs. **Other findings:** As noted in F.3.a.i, there were a significant number of incidents of PRN and Stat medication administrations that were not appropriately documented in the IDNs. **Current recommendations**: 1. Implement strategies to increase compliance with this requirement. 2. Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH's compliance data from the DMH Nursing Services Monitoring PRN

audit, based on an average sample of 15% of PRNs administered each month (May-October 2008), indicated the following:

3.	*Documentation of the individual's response to PRN medications.*	15%
3a.	*In the MTR, there is a brief description of the individual's response to the administered PRN medication, which was documented within one hour of the administration.*	26%
3b.	*In the IDN, there is a comprehensive assessment of the individual's response to the administered PRN medication.*	55%

PSH's PRN comparison data

	Previous period	Current period
Mean compliance rate		
3.	3%	15%
Compliance rate in last month of period		
3.	4%	20%
3.a	4%	30%
3.b	51%	55%

PSH's data demonstrates an overall increase in compliance, but compliance remains low. PSH indicated that the MTR lacks a "Response Time" column, which makes it difficult to determine required timeframes when staff fails to include the time assessed. In addition to the plan of correction noted in F.3.a.ii, HSSs have been instructed to review PRN and Stat documentation regarding the requirements. Also, the Statewide Nursing Workgroup revised the MTR to include a "Time" column for the Response and the revision is currently in the review and approval process.

A review of 50 incidents of PRN medications for 15 individuals (AKR, BRA, CB, CLB, DBP, DLR, JAA, KAF, KBS, LD, NCC, RTH, SA, SLK and VMC) found that 19 incidents had a comprehensive assessment of the individual's response in the IDNs.

PSH's compliance data from the DMH Nursing Services Monitoring Stat audit, based on an average sample of 21% of Stats administered each month (May-October 2008), indicated the following:

3.	*Documentation of the individual's response to Stat medications.*	12%
3.a	*In the MTR, there is a brief description of the individual's response to the administered Stat medication, which was documented within one hour of the administration.*	17%
3.b	*In the IDN, there is a comprehensive assessment of the individual's response to the administered Stat medication.*	52%

Below are PSH's Stat comparison data:

	Previous period	Current period
Mean compliance rate		
3.	4%	12%
Compliance rate in last month of period		
3.	4%	23%
3.a	8%	27%
3.b	39%	59%

Although compliance is low, there has been an increase in the compliance rates from the last review period. PSH indicated that for compliance to

		improve, there needs to be better communication between the RN and the medication administration nurse regarding documentation of observations and findings. A review of 50 incidents of Stat medications for 15 individuals (AH, DAL, GWA, HLE, JG, JW, KLA, KLK, MDG, MLB, SDH, SEJ, TEL, VLM and WMM) found that 23 incidents had a comprehensive assessment of the individual's response in the IDNs. **Current recommendation**: Continue to monitor this requirement.
F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Develop and implement a system to 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. **Findings:** PSH's training rosters verified that as of October 2008, 90% of staff received the training update for NPPM 511, Medication Variance Report. The facility reported that since May 2008, the Nursing Coordinators are provided with the monitoring results of the MTR/MVR findings. However, it was discovered during the tour that there had been a significant breakdown in the data tracking of MVRs and the current data was unreliable. At the time of the review, Standards Compliance was implementing corrective actions that are expected to resolve the data management issue for the next review. **Recommendation 2, June 2008:** Continue to monitor this requirement.

		Findings: PSH reported that from May to October 2008, Standards Compliance auditors identified 93 missing initials on the MTRs but only 19 MVRs had been initiated. In addition, 50 missing signatures were found on the Control Sheet; however, only 26 MVRs had been initiated by the units. No comparison data was provided. PSH identified the barrier to compliance as the 24-Hour Noc Audit not being done consistently or reliably. PSH's plan of correction included the initiation of unannounced MTR and Control Sheet Log audits by Program Management, the Nursing Coordinators, ACNS, and HSS staff in June 2008. Shift Leads have been instructed to review the MTR and Control Sheets and random med pass observations are being conducted by Program Management and Unit Supervisors. In addition, the facility plans to implement Noc Medication Auditors to audit opposite units/programs than their usual assigned units in order to improve validity. A review of the current MTRs and Controlled Sheets for Units 20, 21, 22, 24, 25, 26, and 27 found that there were two signatures missing from the controlled medication log and 135 initials missing on the MTRs. In addition, the MTRs from unit 25 appeared to be pre-signed for all noon medications. The facility could not produce the associated MVRs. **Compliance:** Noncompliance. **Current recommendations**: 1. Implement a tracking system for this requirement to ensure the accuracy of the data. 2. Continue to monitor this requirement.

F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement additional training as scheduled to address this requirement. **Findings:** Since the last review, PSH has made the training on WRP Modules for Foci/Objectives and Interventions required for all RNs. The facility reported that current discussions with the Recreational Therapist who is the trainer for the Foci and Objectives and Interventions are being implemented to develop training specific to the RNs and this should be implemented by the next review. PSH's training rosters verified that as of October 2008, 95% of RNs, 96% of PTs and 95% of LVNs have received and passed the WRP Level 1 training. **Recommendation 2, June 2008:** Develop a system to identify and implement the use of nursing "seniors." **Findings:** The facility has hired two RNs to serve as Health Service Specialists (HSS), which allows an HSS to be assigned to each Program on the AM shift to function as a type of nursing coach until a better solution can be developed. In addition, RNs from each Program and unit have been assigned as a resource for the WaRMSS System. **Recommendation 3, June 2008:** Continue to monitor this requirement. **Findings:** Using the DMH Nursing Interventions audit, PSH assessed its compliance based on an average sample of 11% of WRPs due for the month (May-October 2008). The following table summarizes PSH's data:

1.a	*If a DMH WRP Attachment was developed, it was filed with the previous WRP.*	56%
1.b	*If a DMH Attachment was developed, it has been reviewed and integrated into the current WRP.*	47%
1.c	*There are interventions (both active treatment and in the therapeutic milieu) specific as to how nursing is going to assist the individual in meeting his or her goals for each open focus.*	6%
1.c.i	*Focus 1: Psychiatric and Psychological*	39%
1.c.ii	*Focus 2: Social Skills*	26%
1.c.iii	*Focus 3: Dangerousness and Impulsivity*	42%
1.c.iv	*Focus 4: Hope and Spirituality*	21%
1.c.v	*Focus 5: Substance Abuse*	45%
1.c.vi	*Focus 6: Medical, Health, and Wellness*	26%
1.c.vii	*Focus 7: Legal*	31%
1.c.viii	*Focus 8: School and Education*	33%
1.c.ix	*Focus 9: Occupational Skills*	7%
1.c.x	*Focus 10: Leisure and Recreation*	23%
1.c.xi	*Focus 11: community Integration*	33%
2.a	*The nursing interventions include specific strategies to assist the individual in meeting his or her objectives.*	9%
2.b	*The nursing interventions align and complement other interventions (including interventions in the therapeutic milieu) in the WRP to assist the individual 24 hours a day.*	12%
2.c	*The nursing interventions are written in observable, behavioral, and/or measurable terms.*	5%
3.	*Only the approved DMH forms are used.*	98%
4.	*There are no Nursing Diagnoses (NANDA) statements in the WRP.*	76%

Below are PSH's comparison data demonstrating variability in compliance:

	Previous period	Current period
Mean compliance rate		
1.a	12%	56%
1.b	24%	47%
1.c	12%	6%
2.a	12%	9%
2.b	5%	12%
2.c	1%	5%
3.	74%	98%
4.	68%	76%
Compliance rate in last month of period		
1.a	21%	37%
1.b	52%	43%
1.c	7%	3%
2.a	10%	10%
2.b	8%	11%
2.c	1%	5%
3.	100%	98%
4.	68%	83%

PSH identified several barriers to compliance with this requirement, including the scoring of noncompliance when only hand-written interventions are completed when new medical or behavioral conditions/foci are opened, and the need for additional training on entering objectives and interventions into the WaRMSS System.
In addition to the interventions noted above under Recommendations 1 and 2, nursing is providing the monitoring results for this requirement

		to nurse managers and supervisors to review with staff. Nursing is currently using audit results to identify individual staff's training needs. See also C.2.l for reviewer findings. **Compliance:** Partial. **Current recommendations**: 1. Continue to implement strategies to increase compliance with this requirement. 2. Increase sample size to at least 20%. 3. Continue to monitor this requirement.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH's compliance data from the DMH Nursing Staff Familiarity Monitoring audit, based on an average sample of 51% of total nursing staff for 33 units on the AM/PM shift that could be interviewed, indicated the following: 6. *All Nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual (F.3.d).* 31% 6.a *Nursing staff working with an individual are able to discuss the individual's goals (foci of hospitalization).* 81% 6.b *Nursing staff working with an individual are able to discuss the individual's objectives.* 45%

6.c	*Nursing staff working with an individual are able to discuss the individual's interventions in the therapeutic milieu.*	45%

Below are PSH's comparison data demonstrating variability in compliance:

	Previous period	Current period
Mean compliance rate		
6.	45%	31%
Compliance rate in last month of period		
6.	24%	35%
6.a	76%	72%
6.b	55%	50%
6.c	32%	55%

PSH indicated that the barrier to compliance for this requirement was that nursing staff have not completed all the training regarding WRP Module for Foci and Objectives and the WRP Module for Interventions. PSH has deemed these trainings as required classes for all RNs since the last review. The WRP Modules training schedule is provided to the nursing staff and nursing supervisors each month and nursing is currently using audit results to identify individual staff's training needs.

A review of admission assessments, integrated assessments and WRPs of 43 individuals (AEG, AER, AJ, BGM, CH, CLR, CT, DAC, DMZ, DO, EA, EBW, EDL, GF, GH, GMM, HAB, JCS, JHB, JP, JSC, JWP, LLJ, LRO, MCB, MEM, MGD, MRO, MRR, NB, ND, OFL, PM, PWM, RDH, RJ, RPR, RSB, RWM, TEL, TOM, WPN and WRW) found, as noted in C.2.l, that many of the WRPs contained inadequate and inappropriate nursing objectives and interventions relative to the information contained in the assessments. Also, goals and objectives contained in the admission and

		integrated nursing assessments were frequently inconsistent with the information in the assessments. This finding indicates that staff are not consistently addressing meaningful goals, objectives and interventions for individuals, which overshadows the issue of familiarity with goals, objectives an d interventions. Observations of WRPCs on Units EB-09 and 36 indicated that goals specific to the individuals were discussed; however, the teams maintained the generic goals and objectives that had clearly been met. . **Compliance:** Partial. **Current recommendations**: 1. Continue efforts to provide staff training on all WRP modules. 2. Continue to monitor this requirement.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each 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 recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** The facility reported the following data from the DMH Medical Transfer Audit, based on a 62% sample of individuals transferred to community hospitals each month (May-October 2008): 1. *There is an appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.* 1.a *There is an appropriate identification of the change in the individual's condition including vital signs.* 62% 1.b *There is documentation of when the change in the* 89%

	individual's status changed.	
1.c	*There is documentation of when the physician was notified and the physician's name.*	83%
1.d	*There is timely (immediate for emergent conditions and no later than one hour for urgent conditions) notification by the nurse to the physician.*	62%
1.e	*There is documentation in the record when the individual was transferred from the DMH hospital to the acute medical facility including date and time.*	81%

The facility also reported the following data from the Nursing Shift Change Monitoring data for 33 units' shift reports during the review period (May-October 2008):

6.	*The nursing staff reports to the oncoming shift the target variable that the individual exhibited.*	77%
7.	*The nursing staff discusses with the oncoming shift the specific interventions for the individual, including the appropriate continuum of care across shifts.*	72%

PSH's progress report indicated that there were no comparison data available since the tools for this requirement were revised in May 2008. In addition, PSH indicated that the facility identified several barriers to compliance, but did not describe them.

A review of the records of nine individuals who were transferred to a community hospital or emergency room (ER) during the review period (CLB, DLS, HR, JW, KW, LAB, ND, NPT and VN) found that there has been overall improvement in the nurses' documentation regarding changes in status, status upon transferring to and return from the community hospital/ER. However, some problematic issues were noted. One individual's IDNs did not include a note regarding return from the

		hospital (JW) and one note was found to be inadequate (ND). There continues to be a need to ensure that complete assessments are done and documented regarding bowel sounds when individuals experience abdomen pain. In addition, vital signs that are suspect, such as a blood pressure of 107/104, need to be retaken to ensure accuracy (NPT). The documentation was inconsistent regarding the specific physician that was called regarding the change in status. Other issues included problems with the legibility of some of the IDNs, writing over words, not using the appropriate procedure indicating an error in the documentation and IDNs significantly out of order. In one case (CS), the IDNs regarding the acute change in status could not be located. The implementation of PSH's plan of correction for this requirement should result in continued improvement by the next review. Since the last review, a Statewide Nursing and Physician Work Group has been meeting regarding SO 136, Provision of Medical Care. The group has been working on the specific processes regarding urgent, emergent, and non-urgent assessment criteria, and forms were developed addressing these issues. Hospital-wide training was scheduled to begin in November 2008. These actions should increase compliance with this requirement. Observations of shift report on Unit EB-01 demonstrated that there continues to be a significant lack of clinical information regarding the status of individuals reported from one shift to the next. There is little to no connection made between individuals' status, Axis diagnoses and goals and objectives. PSH has indicated that by the next review, a structure for shift report will have been developed and implemented. Also, the Statewide Nursing Work Group is currently developing a standardized change of shift process, focusing on several components of the change of shift process including person-centered nursing assignments, change of condition, key indicator conditions and trigger

		issues occurring on a shift. **Compliance:** Partial. **Current recommendations**: 1. Continue to implement the training addressing the provision of and administration of medical care. 2. Implement strategies addressing shift report to meet the elements of this requirement. 3. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Increase sample size to 20%. **Findings:** PSH indicated that due to workloads, they were unable to increase the sample size for this review period. (Mean sample size 7% for this review period, May-October 2008) **Recommendation 2, June 2008:** Continue to monitor this requirement. **Findings:** Using the DMH Medication Administration Monitoring audit based on an average sample of 7% of level of care nursing staff who are licensed and medication certified, PSH found the following:

1.	*Nursing staff are knowledgeable regarding each individual's prescribed medications.*	95%
1.a	*If a medication requires vital sign assessment prior to administration, the nursing staff is observed reviewing this reading.*	96%
1.b	*If a medication requires a blood glucose level prior to administration, the nursing staff is observed reviewing this reading.*	99%
1.c	*The nursing staff is able to answer questions about one medication that is administered to the individual. (The question may include purpose of medication, common side effects, etc.)*	97%

Since the monitoring tool for this requirement was revised and implemented in May 2008, there is no comparison data.

Although PSH's compliance data for this requirement indicates a high level of compliance, the sample size is inadequate to accurately generalize the findings. In addition, observations from the medication administration pass on Units 30 and 31 did not support PSH's data. (See F.3.a.i.)

Other findings:
Training rosters verified that as of October 2008, 88% of required staff has completed the annual mandated training Principles of Medication. PSH's system tracks audit findings with the specific staff so that individual training needs can be identified.

Current recommendations:
1. Continue efforts to increase sample size to 20%.
2. Ensure accuracy of the data for this requirement.
3. Continue to monitor this requirement.

F.3.f.ii	education is provided to individuals during medication administration;	**Current findings on previous recommendation:** **Recommendation, June 2008:** See F.3.f.i. **Findings:** The DMH Medication Administration Monitoring audit, based on an average sample of 7% of level of care nursing staff who are licensed and medication certified, found the following: 2. *Education is provided to individuals during medication administration.* 39% 2.a *If an individual asks a question, the nursing staff is able to competently answer the question.* 92% 2.b *When an individual has been prescribed a new medication, the nursing staff provides education about the medication.* 93% 2.c *Nursing staff makes at least one inquiry or comment to the individual about his or her medication at each medication administration.* 40% No comparison data were available since the tool for this requirement was revised in May 2008. PSH indicated that due to workload issues, they were unable to achieve a sample size of 20%. The facility reported that the barrier to compliance was inconsistent staff education of individuals about their medications. In order to increase compliance, Nursing Supervisors will receive data reports for specific staff to identify training needs. In addition, the facility plans to evaluate the current training (Principles of Medication) to ensure that appropriate content and procedures are being taught. As noted in F.3.a.i, observations of medication administration on Units 30 and 31 did not support PSH's data.

		Current recommendation: See F.3.f.i
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** See F.3.f.i. **Findings:** The DMH Medication Administration Monitoring audit, based on an average sample of 7% of level of care nursing staff who are licensed and medication-certified, found the following: 10. *Nursing staff are following the appropriate medication administration protocol.* 100% 10.a *The correct medications are administered.* 100% 10.b *The medications are administered to the correct individual.* 100% 10.c *The medications are administered in the ordered form.* 100% 10.d *The medications are administered by the correct route.* 100% 10.e *The medications are administered at the correct time.* 100% 10.f *The medications are administered on the correct date.* 100% 10.g *The medications are administered for the right indication.* 100% There was no comparison data provided for items 10.a-g due to tool revision in May 2008.

		See F.3.a.i and F.3.b for this monitor's findings. **Other findings:** Based on discussions with Nursing, PSH recognizes that the medication observation data above does not support the findings regarding Medication Variance Reports (F.3.b) and observations made during the review (F.3.f.i). In August 2008, PSH provided the Nursing Supervisors with a demonstration of the appropriate medication pass process and then provided this training to the unit staff. In addition, Program Management and Nursing supervisors are now conducting unannounced random medication pass observations to ensure that the appropriate procedures are being followed. **Current recommendations**: See F.3.f.i.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Current findings on previous recommendation:** **Recommendation, June 2008:** See F.3.f.i. **Findings:** Using the DMH Medication Administration Monitoring audit based on an average sample of 7% of level of care nursing staff who are licensed and medication-certified, PSH found the following: 11.a — *Medication administration is documented in accordance with the appropriate medication administration protocol.* — 97% 11.b — *Nursing staff correctly documents on the MTR to reflect what actually occurred.* — 99% See F.3.a.i and F.3.b for this monitor's findings, which do not support

		PSH's data. **Other findings:** It was noted that the controlled medication log sheets do not clearly specify when counts are actually conducted, such as when the narcotic keys are passed to another staff member by the medication nurse during breaks or lunch hours. The current form only allows for signatures for oncoming and off-going shift changes. Thus, it becomes difficult to accurately verify that the correct count procedures were completed at the appropriate times. **Current recommendations**: 1. Modify the controlled medication signature sheet to accurately reflect when the narcotic counts occur. 2. See F.3.f.i.
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**No recommendations were made in the last report because PSH did not care for any bed-bound individuals.** **Findings:** There were no bed-bound individuals at PSH during the review period. **Compliance:** Not applicable. **Current recommendations**: None.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Partial.

F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Provide data for existing staff. **Findings:** PSH's Recovery-Based Mental Health Nursing training rosters verified that as of October 2008, 910 staff out of 1498 total and 63 out of 65 new employees received the training. **Recommendation 2, June 2008:** Continue to monitor this requirement. **Findings:** Same as above. **Current recommendation**: Continue to monitor this requirement.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH resumed the Therapeutic Milieu training in September 2008 and units attend this training as a team. As of October 2008, PSH's training rosters verified that 57% of nursing services have received the training and 89% have completed the Prevention and Management of Assaultive Behavior (PMAB) Training (now called Therapeutic Strategy Interventions [TSI]).

		Current recommendation: Continue to monitor this requirement.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** Review of PSH's training rosters for PBS verified that as of October 2008, 84% of existing employees and 95% of new employees have completed the training. **Current recommendation**: Continue to monitor this requirement.
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** A review of PSH's training rosters verified that as of October 2008, 88% of required staff has completed the Annual Mandated Training: Principles of Medication. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Alejandro Fernandez, Senior Rehabilitation Therapist 2. Billy Mange, Senior Vocational Rehabilitation Counselor 3. Curt Peters, Senior Rehabilitation Therapist 4. David Firnkoess, Occupational Therapist 5. Debra Taylor-Tatum, Senior Rehabilitation Therapist 6. Denise Byerly, Nurse Instructor 7. Greg Siples, Chief of Rehabilitation Therapy Services 8. Jack Baum, Senior Vocational Rehabilitation Counselor 9. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist 10. Janet Richards, Occupational Therapist 11. Jay Gehrke, Industrial Therapist 12. Jerry Marquez, Physical Therapy Assistant 13. Louis Lacouette, Physical Therapist 14. Mark Camero, Senior Rehabilitation Therapist 15. Michelle Rolle-Roda, Occupational Therapist 16. Mike Gomes, Senior Rehabilitation Therapist 17. Stan Hydinger, Senior Rehabilitation Therapist Reviewed: 1. DMH Rehabilitation Therapy Service Manual 2. DMH Rehabilitation Therapy F.4 Audit Tool and instructions 3. DMH MH-C 9090 POST Monthly Progress Note 4. F.4 audit data for July-October 2008 5. AD 10.51 (POST Process) 6. PSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 7. Records for the following 18 individuals participating in observed Mall groups: ALO, AMO, BD, CD, ECA, HJA, JLG, JM, JTF, KS, MAG, MLB, PEH, RE, REB, SC, TD and WCS

		8. List of individuals who received direct Physical Therapy services from May-October 2008 9. Records for the following five individuals who received direct Physical Therapy services between May-October 2008: AGW, DFV, KCO, MM and TC 10. List of individuals who received direct Speech Therapy services from May-October 2008 11. Records for the following four individuals who received direct Speech Therapy services from May-October 2008: AKA, CH, JAC and PSC 12. List of individuals who received direct Occupational Therapy services from May-October 2008 13. Records for the following five individuals who received direct Occupational Therapy services from May-October 2008: AJB, DAH, DWL, HLS and TLA 14. DMH MH-C 9091 24 Rehabilitation Support Plan guidelines and instructions 15. Vocational Services Enhancement Plan Update 16. VICTORY proposal literature 17. 12-Week Lesson Plan for Music Appreciation 18. 12-Week Lesson Plan for Coping through Music 19. 12-Week Lesson plan for Beginning Guitar 20. 12-Week Lesson Plan for Road to Recovery 21. 12-Week Lesson Plan for Weight Training 22. 12-Week Lesson Plan for Eliminate Stress through Music 23. Training materials, rosters and post-tests for POST process and Vocational Rehabilitation services program 24. Training materials, rosters and post-tests for F.4 audit process 25. Rehabilitation Therapy POST Process 1: Training for Positioning, Transferring and Adaptive Equipment <u>Observed</u>: 1. Music Appreciation PSR Mall group

		2. Coping through Music PSR Mall group 3. Beginning Guitar PSR Mall group 4. Road to Recovery PSR Mall group 5. Weight Training PSR Mall group 6. Eliminate Stress through Music PSR Mall group
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	**Compliance:** Partial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Develop and implement formats for progress notes for Occupational, Physical and Speech Therapy direct treatment that are consistent with those at the other state facilities as well as with individual discipline practice act requirements. **Findings:** The DMH-approved POST Team progress note was implemented October 1, 2008 by Occupational Therapy and November 1, 2008 by Physical Therapy. Progress note implementation for Speech Therapy direct treatment is pending. **Recommendation 2, June 2008:** Provide training to all Rehabilitation Therapy staff (Rehabilitation Therapists, Vocational Rehabilitation staff and POST team members) regarding the role of the RT as WRPT liaison. **Findings:** The facility reported that training on the role of the Rehabilitation

		Therapists at WRPCs occurred service-wide on two occasions. Training on AD #10.51 (POST Process) was provided on 10/08/08 to 49 out of 73 Rehabilitation Therapists. Vocational Services Program Training was provided to 51 out of 73 Rehabilitation Therapists on 10/29/08. This was verified by review of training rosters, training materials, and post-tests. **Recommendation 3, June 2008:** Finalize and implement the F.4 audit tool draft to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and PSR Mall group) and indirect supports (e.g., 24-hour plan, adaptive equipment). **Findings:** The F.4 audit tool draft was implemented in July 2008. The DMH-approved F.4 audit instructions and the corresponding audit tool were implemented September 1, 2008 shortly after receipt of DMH approval. Competency-based training on F.4 auditing was provided to 49 out of 73 Rehabilitation Therapists on 10/02/08, 10/15/08, and 10/22/08. This was verified by review of training rosters and post-tests. **Recommendation 4, June 2008:** Establish inter-rater agreement among staff performing audit prior to implementation. **Findings:** The facility reported that inter-rater agreement for F.4 audits has been met, though no data regarding the percentage rate of agreement was provided. **Other findings:** Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based

on an average sample (stratified by discipline) of 82% of individuals participating in Occupational, Physical, and Speech Therapy direct treatment for each month for the review period of May-October 2008 (total of 108 out of 132). The following outlines the indicators with corresponding mean compliance rates for July-October 2008:

1.	*The provision of direct services by rehabilitation therapy services staff*	
1.a	*There is an appropriate Focus of Hospitalization (typically Focus 6).*	56%
1.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, objective, observable, and/or measurable terms.*	8%
1.c	*The intervention aligned with this objective states what OT, PT, and SLP will do to assist the individual in achieving the objective.*	24%
1.d	*There is documentation in the Present Status Section of the individual's WRP of the current status of interventions provided by the OT, PT, and SLP.*	36%

No comparable data were available from the last evaluation period, as this tool was implemented in July 2008.

The facility's plan to attain substantial compliance with F.4.a.i criteria is to provide mentoring and training to staff individually and in a group format as needed, based on audit results.

The table below presents the number of scheduled vs. actual hours of direct services provided by OT, PT, and SLP during the week of 10/20/08:

	Scheduled	Provided
OT	33	27
PT	9	8
SLP	13	10

The facility reported that some clinic appointments did not occur due to individual refusals and/or conflicting medical (non-POST) appointments.

Other findings:
A review of records of five individuals receiving direct Physical Therapy treatment (AGW, DFV, KCO, MM and TC) found all records in partial compliance with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs, and of documentation of progress with changes to objectives and treatment modalities made as needed. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

1. Foci, objectives and interventions are not consistently included in the WRP.
2. Documentation of progress in Physical Therapy treatment is not consistently documented in the present status section of the WRP.

A review of records of five individuals receiving direct Occupational Therapy treatment (AJB, DAH, DWL, HLS and TLA) found all records in partial compliance with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs, and all but one record (DAH) contained documentation of progress with changes to objectives and treatment modalities made as needed. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following:

		1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Documentation of progress in Occupational Therapy treatment is not consistently documented in the present status section of the WRP. A review of records of four individuals receiving direct Speech Therapy treatment (AKA, CH, JAC and PSC) found all records in partial compliance with F.4.a.i criteria. All records reviewed contained evidence that treatment activities were aligned with assessed needs, and all but one record (CH) contained documentation of progress with changes to objectives and treatment modalities made as needed. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Documentation of progress in Speech Therapy treatment is not consistently documented in the present status section of the WRP. **Current recommendations**: 1. Ensure that data for F.4 audit tool is reliable and valid. 2. Provide quality direct services by Occupational, Physical, and Speech Therapy staff to ensure that there is alignment between assessment findings and treatment activities; changes to programs are made as needed; adequate foci, objectives and interventions are aligned and incorporated into the WRP; and progress with direct services are documented in the present status section of the WRP.

F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs. **Findings:** This recommendation has been partially met. Drafts outlining a process for provision of F.4.a.ii services have been developed and are pending revision, review and implementation. Current drafts do not specify criteria by which the F.4.a.ii service would be indicated. **Recommendation 2, June 2008:** Develop and implement a database to track individuals receiving these services, as well as when staff has completed competency-based training/return demonstration and how often the individual should be re-assessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program. **Findings:** This recommendation has not been met as the F.4.a.ii process and identification of individuals who require this service are pending implementation. **Current recommendations**: 1. Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs with Physical and Occupational Therapy oversight that is available to all individuals who require it facility-wide. 2. Develop and implement a facility-wide database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration if indicated, and how often the individual should be re-assessed by the Physical or

		Occupational Therapist to determine the continued appropriateness of the program.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring and positioning and the need to promote individuals' independence occurs as needed. **Findings:** The Rehabilitation Therapy POST Process 1: Training for Positioning, Transferring and Adaptive Equipment was developed and implemented in September 2008 to track the need for and provision of training to staff as clinically indicated. **Recommendation 2, June 2008:** Ensure that databases for Physical and Occupational Therapy programs implemented by nursing staff, adaptive equipment and 24-hour plans track the need for and provision of competency-based training for individuals and/or staff. **Findings:** The facility reported that this system was implemented in September 2008 and that 46 out of 155 nurses requiring training in September and October were trained to competency. Training will continue until all designated staff is trained to competency over the next reporting period. **Compliance:** Partial.

		Current recommendation: Ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, occurs as needed.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that for all individuals receiving direct treatment by Rehabilitation Therapists, progress towards objectives is documented in the WRP and focus, objectives and interventions are modified as needed. **Findings:** Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample (stratified by discipline) of 15% of individuals participating in Rehabilitation Therapy and Vocational Rehabilitation PSR Mall groups for each month for the review period of May-October 2008 (total of 937 out of 6222). The following outlines the indicators with corresponding mean compliance rates for July-October 2008:

4.	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	
4.a	*There is an appropriate focus of hospitalization.*	69%
4.b	*The objective aligned with this focus of hospitalization is functional for the individual and written in behavioral, observable, and/or measurable terms.*	27%
4.c	*The intervention in the PSR Mall aligned with this objective states the name of the RT Mall facilitator, group name, time and place, and the individual's strengths that will be used by the RT*	30%

	staff to assist the individual in achieving this objective.	
4.d	*There is documentation in the Present Status Section of the individual's WRP of interventions provided by the RT and Voc Rehab.*	15%

No comparable data were available from the last evaluation period, as this tool was implemented July 2008.

The facility analyzed the data and found that the actual number of valid audits was significantly reduced beginning in the month of September due to several factors, which included: WRP documents not being finalized within that reporting month, no RT interventions scheduled in MAPP, and no RT alignment between MAPP and the WRP document. All sub-root cell data results trended upward in the month of October, which indicates improvement.

The facility's plan of correction is for the Supervising Rehabilitation Therapists to ensure that assigned Rehabilitation Therapists receive follow-up training as needed based on audit results.

Recommendation 2, June 2008:
Develop and implement a database to track individuals with 24-hour plans, as well as when staff has completed competency-based training/return demonstration and how often the individual should be re-assessed by the POST team member(s) to determine the continued appropriateness of the plan.

Findings:
The facility reported that the POST coordinator maintains a database that includes all individuals who have 24-hour care plans. The database enables the tracking of data related to training as well as frequency of re-assessment.

Recommendation 3, June 2008:
Ensure that all 12-week lesson plans developed by Rehabilitation Therapists are written for only one focus.

Findings:
The facility reported that a review of all 12-week lesson plans was performed and found that all 179 Rehabilitation Therapy lesson plans have only one focus as of September 1, 2008.

A review of the lesson plans for six PSR Mall groups observed found that all lesson plans were written for only one focus, but that lesson plan focus, objectives, treatment activities, and outcome measures were not aligned for two out of six plans.

Other findings:
Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 92% of individuals with 24-hour Rehabilitation Therapy support plans to assess compliance with timely and adequate provision of Rehabilitation Therapy Services for each month for the review period of May-October 2008 (total of 11 out of 12). The following outlines the indicators with corresponding mean compliance rates for July-October 2008:

4.b	*Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.*	
a.	*The 24-hour Rehabilitation Support Plan was implemented within 28 days of referral.*	100%
b.	*The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP*	33%

No comparable data were available from the last evaluation period, as this tool was implemented July 2008.

The facility analyzed the data and found that although the 24-hour support plans were implemented in a timely manner, inconsistent integration of this information into the present status section resulted in a failure to meet substantial compliance. The facility plans to train all WRPTs to ensure the integration of 24-hour care plan information into the present status section of the WRP during the WRPC.

A review of records of four individuals (DB, DTO, JAC and RR) with 24-hour Rehabilitation Support plans to assess for compliance with provision of timely and adequate Rehabilitation Therapy services found two records (JAC and RR) in substantial compliance and two records (DB and DTO) in partial compliance.

The table below presents the number of scheduled vs. actual hours of PSR Mall services provided by RT and Vocational Rehab during the week of 10/12/08:

	Scheduled	Provided	Compliance
Rehabilitation Therapy	356	303	85%
Vocational Rehabilitation	25	20	80%

The facility analyzed this data and reported that reasons why sessions did not occur included time off, lock-downs, staff shortages, shakedowns, mandatory training and staff illness. The facility reported that 17 Rehabilitation Therapists have been hired over this reporting period, which will help ease the staff shortage issue.

A review of records of eighteen individuals (ALO, AMO, BD, CD, ECA, HJA, JLG, JM, JTF, KS, MAG, MLB, PEH, RE, REB, SC, TD and WCS) participating in PSR Mall groups led by Rehabilitation Therapists to

		assess for compliance with provision of timely and adequate Rehabilitation Therapy services found all records in partial compliance. All records reviewed contained evidence that treatment activities were aligned with assessed needs. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. Objectives are not consistently functional, behavioral, observable and measurable. 2. Foci, objectives and interventions are not consistently included in the WRP. 3. Documentation of progress is not consistently documented in the present status section of the WRP. Significant progress has been made in the area of Vocational Services program development. The VICTORY program proposal was revised to reflect recovery language. A Vocational Services PSR Mall group pilot project was completed, with assistance from a group of individuals who have provided feedback regarding class structure and curriculum; the facility reported that this PSR Mall class will be initiated during the upcoming Mall cycle. Additional Focus 9 groups to be provided in the Easy Street location are in development. A distance learning program and IT assignments for equipment repair are being developed. **Compliance:** Partial. **Current recommendations**: 1. Ensure that for all individuals receiving treatment by Rehabilitation Therapists in PSR Mall groups, progress towards objectives is documented in the present status section of the WRP, and quality foci, objectives, and interventions are documented in the WRP and are aligned.

		2. Provide training to Rehabilitation Therapy staff on writing quality foci, objectives and interventions based on content of the revised PSR Mall Manual. 3. Ensure that all individuals with 24-hour Rehabilitation Support plans meet criteria for 24-hour plans, and receive provision of timely and adequate Rehabilitation Therapy services.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Develop and implement a database to track all individuals with adaptive equipment, including when a piece of equipment is ordered compared to the date of implementation, level of assistance of individual with device, whether training was necessary, when training was provided if appropriate and if/how often the individual should be re-assessed by the POST team member(s) to determine the continued appropriateness of the equipment. **Findings:** A database was developed and implemented in this reporting period, using a model similar to that at MSH. The current database includes all components recommended above. **Recommendation 2, June 2008:** Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence and provide individuals with training and support to use such equipment. **Findings:** Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of individuals added to the adaptive equipment database for each month for the review period of May-

October 2008 (total of 64) for indicators e-h. Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 100% of individuals within the adaptive equipment database who required re-assessment for each month for the review period of May-October 2008 (total of 86) for indicator i. The following outlines the indicators with corresponding mean compliance rates for May-October 2008:

e.	*The individual was assessed for the appropriateness of adaptive equipment by an RT professional*	100%
f.	*The individual was provided with the equipment as per the doctor's order*	100%
g.	*The individual's level of functioning related to independence versus supports needed was assessed.*	25%
h.	*Training for the individual on the use of adaptive equipment was provided.*	100%
i.	*Reassessment of adaptive equipment, if clinically indicated*	72%

No comparable data were available from the last evaluation period, as this tool was implemented July 2008.

Compliance:
Partial.

Current recommendation:
Ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and provide individuals with training and support to use such equipment.

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. Brian Starck-Riley, Assistant Director of Nutrition Services 2. Diana Tran, Assistant Director of Nutrition Services 3. Dolores Otto-Moreno, Assistant Director of Nutrition Services 4. Grace Ferris, Assistant Director of Nutrition Services 5. Jeanie Kim, Assistant Director of Nutrition Services 6. Kitchie Miana, Assistant Director of Nutrition Services 7. Tai Kim, Director of Nutrition Services Reviewed: 1. Lists of individuals with Nutrition Care Assessments due from May-October 2008 for each assessment type 2. Records for the following 66 individuals with type a-j.ii. assessment from May-October 2008: AG, AMO, ANA, ATL, BDS, BEH, BLM, BM, BMS, BN, BRC, BRT, CAZ, CHF, CMJ, CY, DA, DAD, DAR, DET, DLD, ELF, EWM, GCD, GWA, HM, HMM, JAG, JAH, JGR, JLC, JLH, JME, JMP, JP, JPW, JRS, KLA (two assessments), KLD, KS, LES, MB, MJC, MLJ, MN, MS, MS-2, MSR, ND, PLM, RA, RAG, RCH, RDS, RWT, SH, SHW, SMC, SMG, SR, SW, TDW, TM, VGR, VQ and YMV 3. Records of the following six individuals participating in Diabetes and General Nutrition PSR Mall group: DBM, GWD, JC, JCS, KDE and RBK 4. Meal Accuracy Report audit data from May-October 2008 5. Nutrition Care Monitoring Tool audit data from May-October 2008 regarding Nutrition Education Training and response to MNT (weighted mean across assessment sub-types) 6. Audit data for May-October 2008 regarding WRP integration of Nutrition Services recommendations 7. Facility training data and competency scores for RNs and

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<td></td>
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<td>Dietitians, as well as raw data binders
8. Interdisciplinary Weight Management group proposal

<u>Observed</u>:
1. Diabetes PSR Mall group
2. General Nutrition PSR Mall group</td>
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<tr>
<td>F.5.a</td>
<td>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.</td>
<td>Current findings on previous recommendation:

Recommendation, June 2008:
Continue current practice.

Findings:
Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance with these indicators based on an average sample of 26% of Nutrition Assessments (all types) due each month for the review period of May-October 2008 (total of 609 out of 2337). The following presents these indicators with corresponding mean compliance rates for May-October 2008:
<table>
<tr><td>7.</td><td>Nutrition education is documented</td><td>97%</td></tr>
<tr><td>8</td><td>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</td><td>99%</td></tr>
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Comparative data between previous and current period was not provided.

The table below presents the number of scheduled vs. actual hours of PSR Mall services provided by Dietitians during the May-October 2008 review period:</td>
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	Scheduled	Provided	Compliance
Hours provided by Dietitians	240	223	93%

The compliance rate (provided hours/scheduled hours) of93% is an increase from 78% in the previous review period.

According to review of Meal Accuracy Report data, 99% of trays (regular and modified diets) audited from May-October 2008 (total of 2659 out of 9014, for a 30% sample) were 100% accurate.

Other findings:
Observation of two PSR Mall groups facilitated by Dietitians for Diabetes and General Nutrition found that the group facilitators were using lesson plans with corresponding curriculum, and all individuals were engaged. The content of teaching materials was aligned with the individual's assessed needs for five out of six individuals observed.

A review of records of 66 individuals with completed Nutrition Care assessments across sub-types (AG, AMO, ANA, ATL, BDS, BEH, BLM, BM, BMS, BN, BRC, BRT, CAZ, CHF, CMJ, CY, DA, DAD, DAR, DET, DLD, ELF, EWM, GCD, GWA, HM, HMM, JAG, JAH, JGR, JLC, JLH, JME, JMP, JP, JPW, JRS, KLA, KLD, KS, LES, MB, MJC, MLJ, MN, MS, MS-2, MSR, ND, PLM, RA, RAG, RCH, RDS, RWT, SH, SHW, SMC, SMG, SR, SW, TDW, TM, VGR, VQ and YLH) to assess compliance with documentation of provision of Nutrition Education Training and documentation of response to Medical Nutrition Training found two records in partial compliance (DAD and MS), one record (BDS) not in compliance, and the remaining 63 records in substantial compliance.

Compliance:
Substantial.

		Current recommendation: Continue current practice.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement new process changes regarding WRP integration of Nutrition assessment findings and recommendations. **Findings:** In October 2008, Dietitians began entering objectives and interventions into the WRP through the WaRMSS system. The current process is for Dietitians to create a new WRP draft and input data; this process has been approved by the Nutrition director and has been discussed with WRPTs. **Recommendation 2, June 2008:** Continue current practice. **Findings:** Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance with WRP integration based on an average sample of 26% of Nutrition Assessments (all types) due each month for the review period of May-October 2008 (total of 609 out of 2337). The following presents these indicators with corresponding mean compliance rates for May-October 2008: 19. *The WRP has at least ONE focus that pertains to nutrition recommendations as clinically indicated* — 78% 20. *The WRP has at least one objective and interventions linked to the focus that pertains to the nutrition recommendation as clinically indicated* — 54%

		Mean compliance for item19 increased from 61% in the prior review period to 78% in the current review period. No comparable data were available from the previous review period for item 20. Feedback and training has been provided to Dietitians individually on the process for entering Nutrition objectives and interventions into the WRP. The facility reported that RD vacancies continue to impact compliance for both items 19 and 20. The facility's plan for corrective action is to continue to provide training and mentoring to Dietitians with sub-standard performance. Twenty out of 20 nurses hired received training to competency regarding incorporating Nutrition findings into the WRP in New Employee Orientation. This was verified by review of training rosters. **Other findings:** A review of records of 50 individuals with completed Nutrition Care assessments across sub-types (AG, AMO, ANA, ATL, BDS, BLM, BM, BMS, BN, BRC, BRT, CAZ, CHF, CMJ, CY, DAD, DAR, DET, DLD, ELF, GCD, GWA, HM, HMM, JAG, JAH, JLC, JLH, JMP, JP, JPW, JRS, KLA [two assessments], LES, MLJ, MS, MSR, RA, RAG, RDS, RWT, SH, SHW, SMC, SMG, SR, SW, TDW, VGR and YMV) found 14 records in substantial compliance (AG, BLM, BM, BRT, CAZ, CMJ, GCD, HMM, KLA, MSR, RDS, SW, TDW and VGR), 28 records in partial compliance (AMO, ANA, ATL, BDS, BN, BRC, DAD, DAR, DET, DLD, GWA, HM, JAG, JP, JPW, JRS, KLA, MLJ, MS, RA, RAG, RWT, SH, SHW, SMC, SMG, SR and YMV) and nine records not in compliance (BMS, CHF, CY, ELF, JAH, JLC, JLH, JMP and LES) with having an adequate focus, objective and intervention integrated into the WRP. Identified patterns of deficiencies that the facility should focus on in order to improve compliance include the following: 1. WRP Nutrition objectives are not consistently specific, behavioral,

		observable and measurable. 2. WRP Nutrition foci, objectives and interventions are not included in the WRP. A review of records of six individuals (DBM, GWD, JC, JCS, KDE and RBK) participating in Nutrition PSR Mall groups to assess compliance with WRP inclusion of adequate focus, objective and intervention found five records (DBM, JC, JCS, KDE and RBK) in partial compliance and one record (GWD) not in compliance with having documentation of a focus, objective and intervention for the group listed in the WRP, and evidence that treatment activities were aligned with assessed needs. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management addresses the dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. **Compliance:** Substantial.

		Current recommendation: Continue current practice.
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** According to facility report, one new Nutrition employee was hired during the review period and this employee was trained to competency on the dietitian's role in dysphagia management as an intern during a previous review period. At the time of the previous review, it was noted that 100% of dietitians had received dysphagia training to competency. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice. **Compliance:** Substantial.

		Current recommendation: Continue current practice.

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: 1. Phung Chau, Pharmacy Service Manager 2. Washington Ubillus, PharmD, Pharmacist Reviewed: 1. Random sample of recommendations made by pharmacists regarding new psychotropic medication orders 2. PSH self-assessment monitoring data
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Ensure that pharmacists provide recommendations, when appropriate, and resolve implementation barriers. • Continue to monitor this requirement and provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** During this review period, the Pharmacy Department at PSH provided 194 recommendations to the prescribing physicians compared to 91 during the last review. The recommendations appeared to be adequate in terms of their numbers and types. The following summarizes the data: 1. Drug-drug interactions 23 2. Side effects 2 3. Need for laboratory testing 82 4. Dose ranges 13

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<tr><td>5.</td><td>Indications</td><td>2</td></tr>
<tr><td>6.</td><td>Contraindication</td><td>23</td></tr>
<tr><td>7.</td><td>Need for continued treatment</td><td>0</td></tr>
<tr><td></td><td>Other dosage issues</td><td>29</td></tr>
<tr><td>9.</td><td>Drug-food interaction</td><td>20</td></tr>
<tr><td colspan="2">Total number of recommendations</td><td>194</td></tr>
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Recommendations 3 and 4, June 2008:
• Develop and implement an electronic system to ensure consistent documentation.
• Provide IT assistance to pharmacy regarding electronic database and data collection systems.

Findings:
The IT staff at PSH is in the process of implementing these recommendations.

Compliance:
Substantial.

Current recommendation:
Continue to monitor this requirement and provide results.
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<td>F.6.b</td>
<td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</td>
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Current findings on previous recommendations:

Recommendation 1, June 2008:
Continue to monitor this requirement and provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
PSH reported that 164 recommendations received acceptable physician
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responses, out of 194 recommendations. This represented an improvement in the response rate compared to the last review period. The following is a summary of the data:

Recommendations followed	161
Recommendations not followed, but rationale documented	3
Recommendations not followed and rationale/response not documented	30

To improve compliance with this requirement, the Pharmacy Department has been working with the P&T Committee, Senior Psychiatrists, and nursing staff to improve the response rate among physicians. A memorandum has been issued to all physicians to raise the awareness of the requirements for adequate response and documentation in the medical records. In addition, efforts are underway to generate pharmacy recommendations electronically, so that they can be e-mailed to physicians and Senior Psychiatrists for timely follow-up.

Recommendation 2, June 2008:
Provide information about the outcome of follow-up in situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with the recommendation without documented acceptable rationale.

Findings:
The Pharmacy Department reported that during this review period, no individual suffered harm as a result of these situations. This monitor reviewed a random sample of the facility's records regarding these recommendations and found no evidence of adverse clinical outcomes to the individuals when the physicians did not document a response to the pharmacy recommendations. Nevertheless, it is important that

		physicians document a rationale for disregarding recommendations. **Compliance:** Partial. **Current recommendations**: 1. Continue to monitor this requirement and provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 2. Provide information about the outcome of follow-up in situations in which the physician did not respond to the pharmacist's recommendation and/or disagreed with the recommendation without documented acceptable rationale.

7. General Medical Services		
		Methodology: Interviewed: 1. Alan Ta, MD, Physician and Surgeon 2. Bong Doan, MD, Physician and Surgeon 3. Chinh Pham, MD, Physician and Surgeon 4. Cris Elder, RN, Nursing Coordinator 5. Cung Nguyen, MD, Physician and Surgeon 6. Darryl Brown, Administrator of Medical Services 7. Kenny Win, MD, Physician and Surgeon 8. Khue Nguyen, MD, Physician and Surgeon 9. Lawrence Ogbechie, MD, Staff Psychiatrist 10. Luzmin Inderias, MD, Physician and Surgeon 11. Merle Madera, MD, Staff Psychiatrist 12. Mohamed Hafez, MD, Physician and Surgeon 13. Tim Alder, Staff Psychiatrist and MOD 14. Trang Tran, MD, Physician and Surgeon Reviewed: 1. The charts of the following 10 individuals who were transferred to an outside medical facility during this review period: CB, DN, DS, HR, JW, KS, KW, LB, NT and VN 2. DMH's Special Order 136, Provision of Medical Care to Individuals (draft) 3. DMH template for Nurse's Change in Condition Form 4. The revised DMH History and Physical Form template 5. DMH Medical Surgical Progress Notes Audit Form 6. DMH Medical Surgical Progress Notes Audit Form Instructions 7. PSH Medical Surgical Progress Notes summary audit data (May to October 2008) 8. DMH Integration of Medical Conditions into the WRP Audit Form 9. DMH Integration of Medical Conditions into the WRP Audit Form

		Instructions 10. PSH Integration of Medical Conditions into the WRP Audit summary data (May to October 2008) 11. DMH Medical Transfer Audit Form 12. DMH Medical Transfer Audit Form Instructions 13. PSH Medical Transfer Audit summary data (May to October 2008) 14. DMH Diabetes Mellitus Audit Form 15. DMH Diabetes Mellitus Audit Form Instructions 16. PSH Diabetes Mellitus Audit summary data (May to October 2008) 17. DMH Asthma/COPD Audit Form 18. DMH Asthma/COPD Audit Form Instructions 19. PSH Asthma/COPD Audit summary data (May to October 2008) 20. DMH Hypertension Audit Form 21. DMH Hypertension Audit Form Instructions 22. PSH Hypertension Audit summary data (May to October 2008) 23. DMH Dyslipidemia Audit Form 24. DMH Dyslipidemia Audit Form Instructions 25. PSH Dyslipidemia Audit summary data (May to October 2008) 26. DMH SO 262, Risk Management, Draft 27. DMH SO 136, Provision of Medical Care to Individuals, effective November 18, 2008
F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. **Findings:** During this review period, the contract laboratory at Community Hospital of San Bernardino (CHSB) has further developed its data management system to enable online availability to designated PSH practitioners. However, in August 2008, CHSB reported difficulty in

		pulling only PSH's individuals out of the database for PSH physicians to review. Corrective actions are under way to address this issue. **Recommendations 2 and 3, June 2008:** • Implement the revised ADs and Medical Policies and Procedures. • Consolidate the ADs and Policies and Procedures that address consultation services. **Findings:** PSH has implemented its revised ADs and Medical Policies and Procedures regarding medical services. These tools are aligned with the DMH's draft SP 136, Provision of Medical Care to Individuals. A statewide group is in the process of finalizing the draft. **Recommendation 4, June 2008:** Finalize standardized tools to audit the initial medical assessment and the medical emergency response system. **Findings:** The DMH is still in the process of implementing this recommendation. **Recommendation 5, June 2008:** Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (noted in Other Findings of cell F.7.a in the June 2008 report). **Findings:** During this review period, PSH has taken the following actions to implement this recommendation: 1. In October 2008, training was provided to the medical staff and nurse practitioners in a variety of areas pertaining to the facility's efforts in implementing the EP. These areas included the following:

a. RN and physician communication regarding physical status change;
b. Transfer to and return from another facility for evaluation and/or medical/surgical treatment;
c. Physician and nursing notes regarding transfer of individuals to outside facilities for emergency or other services;
d. Physician orders for the transfer of individuals; and
e. Nursing documentation of changes in the physical status of individual.

2. The DMH has developed a draft SO for Risk Management that includes adequate mechanisms to address physical risk factors. In October 2008, PSH implemented the incident/trigger portion of this SO. The facility also implemented the Medical Risk Management Committee to review the status of individuals with high-risk medical concerns, including individuals post acute care hospitalization.
3. The DMH has developed draft revisions of the formats and protocols of nursing assessment and documentation of change in individuals' physical status. PSH has begun implementation of the new nurses' note of Change in Condition.

Other findings:
This monitor reviewed the charts of 10 individuals who were transferred to an outside medical facility during this reporting period (CB, DN, DS, HR, JW, KS, KW, LB, NT and VN). The following table outlines the individuals' initials, date/time of physician evaluation at the time of transfer and the reason for the transfer:

Individual	Date of MD evaluation	Reason for transfer
1.	05/05/08 20:00	Series of seizures (new onset)

Individual	Date of MD evaluation	Reason for transfer
2.	09/26/08 02:30	Hypotension
3.	09/10/08 11:00	Small bowel obstruction
4.	06/06/08 21:00	Seizure activity
5.	06/09/08 20:20	Seizure activity
6.	08/16/08 14:30	Seizure activity
7.	04/29/08 24:00	R/O bowel obstruction
8.	06/18/08 16:10	R/O bowel obstruction
9.	10/17/08 10:00	Abdominal pain
10.	05/13/08 10:45	Severe abdominal pain

The review found general evidence of timely and appropriate care in most charts. In particular, there was evidence of improved documentation of nursing assessments of changes in the physical status of the individuals in some of the charts that contained the new Change in Condition Form. However, this monitor found a pattern of process deficiencies regarding the delivery of medical services. These deficiencies must be corrected to achieve substantial compliance with this requirement. The following are examples:

1. Upon the return of an individual following hospitalization for unexplained hypotension, the physician acceptance note did not

		include any conclusions regarding the outcome of hospitalization or information regarding factors contributing to the episode. There was no subsequent medical documentation of this information at any time. 2. Some physicians were unclear about the circumstances for nursing documentation of an acute change in the status of an individual (using IDN or Activating Event Form). 3. The nurse's assessment of an individual suffering from abdominal pain did not include an examination of the individual (other than obtaining vital signs). 4. The medical evaluation of an individual who was suffering from abdominal pain and fever did not include an examination of the individual's abdomen. 5. The nurse's assessment of an individual who suffered from grand mal seizures did not include any description of the motor status of the individual during the seizure. There was no morphological diagnosis in the chart of the type of seizure disorder. 6. The medical evaluation of an individual status post presumed seizure activity did not document an adequate examination and assessment. 7. The acceptance note by a physician upon the return transfer of an individual who suffered from recurrent seizure did not include any information regarding possible contributing factors. 8. There was no documentation of a nursing assessment of an individual who was noted to be restless and having difficulty sleeping without known history of having these symptoms. The individual was later diagnosed with R/O bowel obstruction. 9. The nurse's documentation of physician notification did not specify the physician notified. 10. Upon the return transfer of an individual who developed new onset seizure activity, the physician acceptance note addressed some possible contributing factors. However, the note did not address the likely contribution of newly initiated clozaril treatment or

		assess factors contributing to an unexplained elevation in liver enzymes. **Compliance:** Partial. **Current recommendations**: 1. Ensure easy access by physicians to the laboratory information system, radiology data/reports, chart notes and consultation reports. 2. Finalize DMH SO 136, Provision of Medical Care to Individuals and ensure that all facilities' ADs and medical policies and procedures are aligned with the finalized SO. 3. Finalize new formats and protocols for nursing assessment and documentation of changes in the status of individuals, and provide training to ensure proper implementation. 4. Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other Findings above).
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Same as in F.7.a. **Findings:** Same as in F.7.a.

Recommendation 2, June 2008:
Same as in D.1.c.i.

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

Recommendations 3 and 4, June 2008:
- Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample.
- Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
PSH used the DMH Medical-Surgical Progress Note Auditing Form to assess compliance (May to October 2008). The average sample was 20% of individuals with at least one diagnosis on Axis III. The following is a summary of the data:

1.	*There is a quarterly note that documents reassessment of the individual medical status.*	54%
2.	*Significant conditions for which the individual is at risk for complications are identified.*	92%
3.	*If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call (after hours) physician regarding changes in the individual's physical condition.*	25%

Comparative data showed broad improvement in compliance since the last review as follows with the exception of item 1.g:

	Previous period	Current period
Mean compliance rate		
1.	32%	54%
2.	37%	92%
3.	12%	25%
Compliance rate in last month of period		
1.	33%	59%
1.a	60%	71%
1.b	83%	94%
1.c	84%	87%
1.d	87%	91%
1.e	58%	84%
1.f	63%	85%
1.g	87%	81%
2.	82%	90%
2.a	89%	100%
2.b	91%	95%
2.c	85%	95%
2.d	70%	88%
3.	5%	64%
3.a	8%	68%
3.b	57%	74%
3.c	50%	78%

PSH reported that beginning in November 2008, all Physicians and Surgeons will be trained on requirements of the DMH SO 136 and provided an individualized summary of their performance across all F.7 auditing data no less than quarterly. Specific mentoring will be implemented to improve performance, as indicated.

		Compliance: Partial. **Current recommendations**: 1. Same as in F.7.a. 2. Same as in D.1.c.i. 3. Monitor this requirement using the DMH Medical-Surgical Progress Note Auditing Form based on at least a 20% sample. 4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.7.b.ii	require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Develop and implement a system to assess timeliness and appropriateness of consultation services. **Findings:** PSH's data did not adequately address this recommendation. The facility provided data regarding self-assessment of current systems of reporting radiology, EKG and other laboratory services as well as activation of the current medical emergency response system. As in the previous report, the data showed 100% compliance in all areas. **Recommendations 2 and 3, June 2008:** • Monitor this requirement using the DMH standardized tools regarding Medical Transfers and Integration of Medical Conditions into the WRP based on at least a 20% samples. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

Findings:
PSH used the DMH Medical Transfer Auditing Form to assess compliance (May to October 2008). The average sample was 100% of the transfers. The following is a summary of the data:

1.	*There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.*	70%
2.	*There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.*	63%
3.	*Sufficient information is provided to the accepting facility in order to ensure continuity of care.*	46%
4.	*Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.*	73%
5.	*Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.*	79%
6.	*Timely written progress notes by the regular medical physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.*	84%
7.	*The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.*	51%

Comparative data showed mixed changes in compliance, including some examples of significant performance improvement, since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	66%	70%
2.	59%	63%
3.	14%	46%
4.	50%	73%
5.	69%	79%
6.	78%	84%
7.	20%	51%
Compliance rate in last month of period		
1.	61%	63%
1.a	97%	89%
1.b	97%	95%
1.c	63%	68%
1.d	97%	94%
1.e	91%	92%
2.	43%	59%
2.a	95%	88%
2.b	89%	81%
2.c	92%	89%
2.d	80%	86%
2.e	78%	81%
2.f	62%	74%
3.	11%	54%
3.a	46%	69%
3.b	3%	42%
3.c	3%	44%
3.d	23%	55%
3.e	9%	58%
3.f	3%	67%

3.g	3%	71%
3.h	9%	82%
4.	67%	86%
5.	69%	76%
5.a	71%	79%
5.b	71%	83%
5.c	75%	83%
6.	81%	78%
6.a	83%	77%
6.b	85%	83%
7.	28%	43%
7.a	31%	46%
7.b	36%	60%

PSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance (May to October 2008). The average sample was 13% of all individuals with at least one diagnosis on Axis III. The following is a summary of the data:

1.	*All medical conditions listed in Axis III are included on the Medical Conditions form*	64%
2.	*The WRP includes a focus statement, objective and intervention for each medical condition listed on the Medical Conditions form*	56%
3.	*There is an appropriate focus statement for each medical condition or diagnosis*	5%
4.	*There is an appropriate objective for each medical condition or diagnosis*	8%
5.	*There are appropriate intervention(s) for each objective*	1%

Comparative data again showed mixed changes in compliance since the

last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	48%	64%
2.	43%	56%
3.	7%	5%
4.	4%	8%
5.	1%	1%
Compliance rate in last month of period		
1.	58%	61%
2.	66%	50%
2.a	52%	52%
2.b	70%	58%
2.c	69%	57%
3.	4%	9%
4.	6%	8%
5.a	69%	50%
4.b	7%	8%
4.c	51%	8%
5.	2%	0%
5.a	59%	59%
5.b	8%	8%
5.c	6%	5%
5.d	6%	5%
5.e	33%	17%

The facility reported corrective action plans based on sharing results of the audits with the appropriate departments and providing training to practitioners regarding the implementation of DMH SO 136, Provision of Medical Care to Individuals.

		Other findings: As mentioned earlier, the DMH has yet to finalize a standardized tool to audit the medical emergency response. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Medical Transfer and Integration of Medical Conditions into the WRP Auditing Forms to assess compliance (May to October 2008). 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 3. Standardize the monitoring tools regarding the medical emergency response system and drills for use across state facilities and provide monitoring data based on this tool. 4. Develop and implement a system to assess timeliness and appropriateness of various specialty consultation services.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that the duty statement is aligned with the standardized tools and medical policies and procedures upon their completion. It will be sufficient if the duty statement makes reference to the revised ADs and Policies and Procedures. **Findings:** The facility reported that the duty statements will be modified pending finalization of the DMH's Special Orders regarding Provision of Medical Care to Individuals and Risk Management.

		Compliance: Partial. **Current recommendation**: Finalize DMH SOs regarding Provision of Medical Care to Individuals and Risk Management, and align the duty statements with these SOs.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice and ensure psychiatric input in all psychiatric emergencies that occur after-hours in all sections of the facility. **Findings:** PSH has continued its practice. The facility's MOD schedule showed that at least one psychiatrist is on duty at all times. **Compliance:** Substantial. **Current recommendation**: Continue current practice
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Continue efforts to improve receipt of records from regional medical centers. • Provide self-assessment data regarding this requirement. **Findings:** PSH reviewed the timeliness and completeness of records received

		following hospitalizations, emergency room visits and off-site consultations. The facility reported a compliance rate of 27% during this review period. The main barrier to compliance was ongoing difficulty in obtaining records from Arrowhead Regional Medical Center (ARMC) despite further efforts by PSH to ensure collaboration between the two facilities. PSH is considering further interventions to resolve this issue. **Compliance:** Partial. **Current recommendations**: 1. Continue efforts to improve receipt of records from regional medical centers. 2. Provide self-assessment data regarding this requirement.
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Monitor this requirement using the DMH standardized tools for specific medical conditions, based on at least a 20% sample. • Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). **Findings:** PSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD (May to October 2008). The average samples were 18% (diabetes mellitus), % 17% (COPD/asthma), 19% (hypertension) and 20% (dyslipidemia) of individuals diagnosed with these disorders. The following is a summary of the facility's data and corrective actions to improve compliance.

Diabetes Mellitus

1.	*The individual has been evaluated and supporting documentation is completed at least quarterly.*	76%
2.	*HgbA1C was ordered quarterly.*	70%
3.	*The HgbA1C is equal to or less than 7%.*	90%
4.	*Blood sugar is monitored regularly.*	91%
5.	*Urinary micro albumin is monitored annually.*	66%
6.	*If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.*	82%
7.	*The lipid profile is monitored on admission or time of diagnosis and at least annually.*	96%
8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriate treat the LDL.*	89%
9.	*Blood pressure is monitored weekly.*	75%
10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.*	93%
11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually.*	73%
12.	*Podiatry care was provided by a podiatrist at least annually.*	72%
13.	*A dietary consultation was considered and the recommendation followed, as applicable.*	80%
14.	*Diabetes is addressed in Focus 6 of the WRP.*	91%
15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition.*	60%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	56%	76%
2.	50%	70%
3.	79%	90%
4.	82%	91%
5.	56%	66%
6.	64%	82%
7.	81%	96%
8.	75%	89%
9.	55%	75%
10.	75%	93%
11.	79%	73%
12.	54%	72%
13.	72%	80%
14.	92%	91%
15.	70%	60%
Compliance rate in last month of period		
1.	69%	75%
2.	47%	89%
3.	90%	97%
4.	77%	92%
5.	46%	71%
6.	91%	83%
7.	77%	97%
8.	81%	92%
9.	56%	83%
10.	88%	95%
11.	74%	78%
12.	63%	76%

13.	77%	85%
14.	87%	100%
15.	50%	72%

Asthma/COPD

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	73%
2.	*For individuals with a diagnosis of COPD, a baseline chest x-ray has been ordered.*	77%
3.	*If a rescue inhaler is being used more than two days a week, the individual has been assessed and an appropriate plan of care has been developed.*	77%
4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.*	48%
5.	*Asthma or COPD is addressed in Focus 6 of the WRP.*	88%
6.	*Focus 6 for asthma/COPD has appropriate objectives and interventions.*	55%
7.	*The individual has been assessed for a flu vaccination.*	55%
8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.*	58%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	54%	73%
2.	67%	77%

3.	44%	77%
4.	50%	48%
5.	83%	88%
6.	69%	55%
7.	54%	55%
8.	31%	58%
Compliance rate in last month of period		
1.	75%	76%
2.	68%	79%
3.	40%	95%
4.	43%	64%
5.	72%	94%
6.	50%	76%
7.	40%	92%
8.	38%	85%

Hypertension

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	75%
2.	*Blood pressure is monitored weekly.*	90%
3.	*Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.*	96%
4.	*If the individual is 40 or older, aspirin has been ordered unless contraindicated.*	78%
5.	*Hypertension is addressed in Focus 6 of the WRP.*	94%
6.	*Focus 6 for hypertension has appropriate objectives and interventions.*	56%
7.	*A dietary consult was considered and the recommendation was followed, as applicable.*	75%
8.	*The BMI is less than or equal to 25 and the waist*	75%

	circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.	
9.	*An exercise program has been initiated.*	57%
10.	*If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.*	49%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous period	Current period
Mean compliance rate		
1.	60%	75%
2.	91%	90%
3.	92%	96%
4.	63%	78%
5.	91%	94%
6.	75%	56%
7.	67%	75%
8.	51%	94%
9.	46%	56%
10.	36%	49%
Compliance rate in last month of period		
1.	70%	71%
2.	96%	96%
3.	97%	98%
4.	68%	77%
5.	92%	89%
6.	63%	62%
7.	73%	82%
8.	48%	90%

9.	29%	74%
10.	24%	53%

Dyslipidemia

1.	*The individual has been evaluated and supporting documentation completed at least quarterly.*	76%
2.	*A lipid panel was ordered at least quarterly.*	71%
3.	*The HDL level is >40(M) or >50(F) or a plan of care is in place.*	81%
4.	*The LDL level is ≤130 or a plan of care is in place.*	92%
5.	*The triglyceride level is ≤ 200 or a plan of care is in place.*	93%
6.	*Dyslipidemia is addressed in Focus 6 of the WRP.*	89%
7.	*Focus 6 for dyslipidemia has appropriate objectives and interventions for this condition.*	51%
8.	*A dietary consultation was considered and the recommendation followed, as applicable.*	79%
9.	*BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.*	80%
10.	*An exercise program has been initiated.*	67%
11.	*If non-pharmacological interventions have been ineffective to control dyslipidemia, medications have been considered or initiated.*	92%

Comparative data showed improvement in compliance for most items since the last review as follows:

	Previous	Current

	period	period
Mean compliance rate		
1.	50%	76%
2.	60%	71%
3.	71%	81%
4.	83%	92%
5.	87%	93%
6.	90%	89%
7.	69%	51%
8.	67%	79%
9.	55%	80%
10.	55%	67%
11.	86%	92%
Compliance rate in last month of period		
1.	69%	71%
2.	65%	78%
3.	86%	79%
4.	89%	93%
5.	91%	94%
6.	87%	92%
7.	53%	79%
8.	78%	75%
9.	59%	80%
10.	50%	87%
11.	82%	91%

To improve compliance with this requirement, the facility reported the same corrective actions that were outlined in F.7.b.i. In addition, the Chief of Psychiatry, Nurse Administrator, and Standards Compliance Director (with consultation from the statewide nurse consultant) are developing a plan to provide direct mentoring to nursing staff regarding implementation and documentation of conditions in Focus 6.

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using the DMH standardized tools for specific medical conditions, based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Implement the Physician Performance Profile and utilize the data in the processes of reappointment and reprivileging. **Findings:** PSH reported that its medical staff has chosen to use a peer review system that does not utilize the facility's self-assessment data. The facility did not provide specific information regarding this system. **Recommendation 2, June 2008:** Continue to update practice guidelines guided by current literature and relevant clinical experience. **Findings:** PSH did not update its practice guidelines during this review period. **Recommendation 3, June 2008:** Provide peer review data analysis regarding practitioner and group trends, with corrective actions, as indicated.

		Findings: PSH has yet to implement this recommendation. The facility reported that beginning in November 2008, all physicians and surgeons will be provided an individualized summary of their performance across all F.7 auditing tools no less than quarterly. The summary will include data regarding the following areas of performance: 1. Timeliness of documentation; 2. Quality of care; 3. WRP planning and documentation; 4. Appropriate consultations ordered; 5. Appropriate consultations reviewed; 6. Appropriate labs/diagnostic tests ordered; and 7. Appropriate labs/diagnostic tests reviewed. **Recommendation 4, June 2008:** Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated. **Findings:** PSH did not address this recommendation. **Recommendation 5, June 2008:** Finalize efforts to automate data systems to facilitate data collection and analysis. **Findings:** PSH reported that the WaRMSS Incident Management and Risk Management Modules have been developed to facilitate data collection and analysis. Implementation data is anticipated in June 2009. **Compliance:** Partial.

		Current recommendations: 1. Develop and implement a quality performance profile for the physicians and surgeons. 2. Provide a summary description of the current physician peer review system and how the system is utilized in reprivileging of the physicians and surgeons. 3. Provide peer review data analysis regarding practitioner and group trends, with corrective actions as indicated. 4. Update practice guidelines guided by current literature and relevant clinical experience. 5. Identify trends and patterns in the health status of individuals based on clinical and process outcomes, with corrective actions, as indicated. 6. Implement current efforts to facilitate data collection in medical risk management.

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. Chloe Cummings, PHN II 2. Cindy Blaire, RN 3. Donna Rowe, PHN II 4. Regina Olender, Nurse Administrator 5. Rose Bui, MD, PHO Reviewed: 1. PSH's progress report and data 2. PSH Infection Control Committee meeting minutes dated 5/15/08, 6/12/08, 7/10/08, 8/14/08, 9/11/08 and 10/16/08 3. Medical records for the following 139 individuals: AEG, AF, AFF, AJ, AJP, AKS, AM, AMB, AP, AS, AVM, AW, BCT, BGM, BJK, BKS, BT, BWS, CB, CBH, CC, CDK, CDM, CH, CL, CLS, CLT, CPC, CS, CT, CW, DAC, DLC, DLD, DLL, DTR, EA, ED, EDL, EEE, EG, EJM, EKS, EL, ELP, ER, FB, GA, GC, GDC, GF, GH, GJW, GM, GMM, GST, HAB, JA, JCM, JDH, JEL, JH, JHB, JJD, JJH, JLM, JP, JS, JSC, JSC, JWP, KHC, KLD, KR, LAS, LLJ, LLO, MA, MAC, MAM, MAW, MBG, MCB, MDD, MEM, MFG, MG, MGD, MGT, MJ, MM, MRO, MSD, MW, NB, ND, NG, OFL, ORL, PDH, PF, PM, PWM, RAG, RAS, RAW, RB, RDH, RDS, REJ, RJ, RJW, RLM, RMC, RRI, RS, RSB, RSO, RVM, RWM, SDM, SGM, SJP, SM, SMS, TDR, TEL, TM, TMW, TOM, TS, TW, VFR, WM, WPN, YMV, YMW, YT and ZHO
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial (due to low compliance related to the WRP integration of Infection Control issues).

F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings (by test/disease):** **<u>Admission PPD</u>** The DMH IC Admission PPD Audit, based on an average sample of 77% of individuals admitted to the hospital with a negative PPD in the review months (May-October 2008), demonstrated the following:

1.	*Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.*	49%
2.	*PPDs were ordered by the physician during the admission procedure.*	98%
3.	*PPDs were administered by the nurse within 24 hours of the physicians order.*	83%
4.	*First-step PPDs were read by the nurse within seven days of administration.*	90%
5.	*Second-step PPDs were read by the nurse within 48-72 hours of administration.*	87%

<u>F.8.a.ii: Assesses these data for trends</u>
PSH's data demonstrated modest increases in mean compliance for all the items listed below:

	Previous period	Current period
Mean compliance rate		
1.	47%	49%
2.	93%	98%
3.	82%	83%

	Previous period	Current period
Mean compliance rate		
4.	87%	90%
5.	82%	87%
Compliance rate in last month of period		
1.	63%	50%
2.	97%	99%
3.	78%	83%
4.	93%	93%
5.	74%	87%

F.8.a.iii: Initiates inquiries regarding problematic trends
At the monthly Infection Control Committee and the Quality Improvement meeting, the Infection Control Physician discusses units that are noncompliant regarding returning the PPD tracking forms.

F.8.a.iv: Identifies necessary corrective action
The Infection Control Department notifies the Nursing Coordinator each month about deficiencies within his/her program.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Although significant efforts have been made to notify Program Management of the units' failures to return the PPD tracking form, only a slight improvement in compliance has been achieved. PSH has requested and been approved for an immunization/PPD team that will provide all of the required immunizations as well as PPDs. It is expected that this process will ensure that substantial compliance is achieved.

A review of the records of 29 individuals admitted during the review period (AEG, AJ, BGM, CH, DAC, EA, EDL, GF, GH, GMM, HAB, JHB,

JSC, LLJ, MCB, MEM, MGD, NB, ND, OFL, PM, PWM, RDH, RJ, RSB, RWM, TEL, TOM and WPN) found that 27 were in compliance.

Annual PPD

The DMH IC Annual PPD Audit, based on an average sample of 56% of individuals needing an annual PPD during the review months (May-October 2008), demonstrated the following:

1.	*Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.*	36%
2.	*PPDs were ordered by the physician during the annual review procedure.*	94%
3.	*PPDs were administered by the nurse within 24 hours of the order.*	70%
4.	*PPDs were read by the nurse within 48-72 hours of administration.*	87%

F.8.a.ii: Assesses these data for trends

Overall, mean compliance scores have increased or been maintained:

	Previous period	Current period
Mean compliance rate		
1.	22%	36%
2.	93%	94%
3.	64%	70%
4.	87%	87%
Compliance rate in last month of period		
1.	9%	55%
2.	88%	93%
3.	75%	67%
4.	80%	85%

F.8.a.iii: Initiates inquiries regarding problematic trends
There was no trend identified of individuals converting from negative to a positive PPD while in the facility.

F.8.a.iv: Identifies necessary corrective action
The Infection Control Department notifies the Nursing Coordinator each month about deficiencies within his/her program.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
As noted above for Admission PPDs, only a slight improvement in compliance has been achieved regarding PPD tracking sheets. The implementation of the immunization/PPD team should increase compliance with item 1.

A review of the records of 20 individuals who were due for an annual PPD during the review period (AFF, AJP, AS, AW, BCT, BKS, BWS, CBH, EG, GC, GDC, GJW, GST, LLO, ORL, PF, RAG, REJ, RRI and RSO) found that 14 were in compliance.

Hepatitis C
The DMH IC Hepatitis C Audit, based on an average sample of 86% of individuals admitted to the hospital who are positive for Hepatitis C in the review months (May-October 2008), demonstrated the following:

1.	*Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.*	100%
3.	*Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual*	100%

	testing positive for Hepatitis C Antibody.	
4.	*The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.*	47%
5.	*A Focus 6 is opened for Hepatitis C.*	99%
6.	*Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet.*	41%
7.	*Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual.*	7%

F.8.a.ii: Assesses these data for trends

There were overall increases in mean compliance with the exception of item 4, which decreased:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	99%
3.	71%	100%
4.	67%	47%
5.	91%	99%
6.	23%	41%
7.	0%	7%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	90%	100%
4.	90%	17%
5.	90%	100%
6.	10%	50%
7.	0%	17%

F.8.a.iii: Initiates inquiries regarding problematic trends
There has been no trend of Hepatitis C conversion identified. The Infection Control liaison nurse has been working directly with each unit nurse who cares for an individual diagnosed with Hepatitis C regarding the WRPs. The nurses' plans of care are not consistently incorporated into the finalized WRP if the nurse is using a Word version of the WRP attachment instead of the WaRMSS version of the WRP attachment (this is scored as noncompliant).

F.8.a.iv: Identifies necessary corrective action
The Executive Director has requested that the Nurse Administrator have the HSS staff ensure that nursing staff are trained regarding the WaRMSS attachment. The Infection Control liaison nurse emails the physician when deficits are found.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
At the time of this review, there has not been sufficient time since the initiation of corrective actions to determine if compliance has improved. PSH will continue to monitor the data.

A review of the records of 21 individuals with a diagnosis of Hepatitis C (AF, AMB, BJK, CC, DLL, EA, EJM, GH, JA, JH, JWP, KR, MAC, MAM, MAW, RS, SDM, SM, TS, TW and YMW) found that only four were in compliance due to problematic issues related to the WRP.

HIV Positive
The DMH IC HIV Positive Audit, based on a 100% sample (10 individuals) of individuals who were positive for HIV antibody in the review months (May-October 2008), demonstrated the following:

1.	*Notification by the lab was made to the infection control department identifying the individual with a*	100%

	positive HIV antibody.	
2.	*Notification was made to the unit housing the individual that he/she has a positive HIV antibody test.*	100%
3.	*If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.*	100%
4.	*If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.*	100%
5.	*The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.*	100%
6.	*A Focus 6 is opened for HIV (unspecified viral illness).*	90%
7.	*Appropriate objective is written to address the progression of the disease.*	70%
8.	*Appropriate interventions are written.*	70%

F.8.a.ii: Assesses these data for trends

There has been significant improvement in items 7 and 8:

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	99%
3.	100%	100%
4.	100%	100%
5.	75%	100%
6.	100%	90%
7.	0%	70%

	Previous period	Current period
Mean compliance rate		
8.	0%	70%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	100%	100%
4.	100%	100%
5.	100%	100%
6.	100%	100%
7.	0%	67%
8.	0%	67%

F.8.a.iii: Initiates inquiries regarding problematic trends
No problematic trends were identified.

F.8.a.iv: Identifies necessary corrective action
No corrective actions were required.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Infection Control Department will continue to monitor these items for compliance.

A review of the records of seven individuals diagnosed HIV-positive (DTR, JLM, JSC, KLD, MW, RDS and RJW) found that five were in compliance.

Immunizations
The DMH IC Immunization Audit, based on an average sample of 83% of individuals admitted to the hospital during the review months (May-October 2008), demonstrated the following:

1.	*Notification by the lab was made to the Infection Control Department of an individual's immunity status.*	100%
2.	*Notification by the lab was made to the unit housing the individual of his/her immunity status.*	97%
3.	*Immunizations were ordered by the physician within 30 days of receiving notification by the lab.*	90%
4.	*Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.*	69%

F.8.a.ii: Assesses these data for trends

There has been some variability in the compliance data.

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	97%
3.	56%	90%
4.	67%	69%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	94%
3.	54%	100%
4.	74%	67%

F.8.a.iii: Initiates inquiries regarding problematic trends

The administration of immunizations by unit nurses within the required 24-hour timeframe remains problematic.

F.8.a.iv: Identifies necessary corrective action
The Infection Control liaison nurse has reinforced the requirement with nursing staff.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The addition of an immunization/PPD team has been approved by administration and is expected to increase compliance.

A review of the records of 29 individuals regarding immunizations (AEG, AJ, BGM, CH, DAC, EA, EDL, GF, GH, GMM, HAB, JHB, JSC, LLJ, MCB, MEM, MGD, NB, ND, OFL, PM, PWM, RDH, RJ, RSB, RWM, TEL, TOM and WPN) found that 16 were in compliance.

Immunization Refusals
The DMH IC Immunization Refusal Audit, based on a 100% sample (26 individuals) of individuals in the hospital who refused to take their immunizations during the review months (May-October 2008), demonstrated the following:

1.	*Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s).*	92%
2.	*There is a Focus 6 opened for the refusal of the immunization(s).*	19%
3.	*There are appropriate objective(s) developed for the refusal of immunization(s).*	0%
4.	*There are appropriate interventions written for the objective(s) developed for the refusal of immunization(s).*	0%
5.	*The unit notified the Infection Control Department when the individual consented and received the immunization(s).*	0%

F.8.a.ii: Assesses these data for trends
Aside from compliance for item 1, which significantly increased, compliance remains very low.

	Previous period	Current period
Mean compliance rate		
1.	8%	92%
2.	12%	19%
3.	4%	0%
4.	4%	0%
5.	12%	0%
Compliance rate in last month of period		
1.	0%	100%
2.	0%	33%
3.	0%	0%
4.	0%	0%
5.	0%	0%

F.8.a.iii: Initiates inquiries regarding problematic trends
The WRPTs are not appropriately addressing refusals within the WRP. If it is addressed, it is usually a generic foci statement, objectives and interventions and the auditor is unable to determine what the individual is actually refusing. Since the units have not been consistently notifying the Infection Control Department about refusals, the liaison nurse is not able to provide assistance.

F.8.a.iv: Identifies necessary corrective action
The WRP mentors have been addressing the need for the WRPTs to developing a plan of care for refusals.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
When fully implemented, the Immunization/PPD team will notify the

Infection Control Department of an individual's refusal of immunizations. This notification will enable the Infection Control liaison nurse to work directly with the WRPT to incorporate an appropriate plan of care for refusal.

A review of the records of 10 individuals who refused immunizations (BT, CB, ELP, MA, MM, MSD, RMC, SGM, SMS and TM) found that none were in compliance.

MRSA

The DMH IC MRSA Audit, based on an 88% average sample (24 individuals) of individuals in the hospital who tested positive for MRSA during the review months (May-October 2008), demonstrated the following:

1.	*Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.*	100%
2.	*Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained.*	100%
3.	*The individual is placed on contact precaution per MRSA policy.*	81%
4.	*The appropriate antibiotic was ordered for treatment of the infection(s).*	100%
5.	*The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.*	95%
6.	*A Focus 6 is opened for MRSA.*	81%
7.	*Appropriate objective is written to include prevention of spread of infection.*	72%
8.	*Appropriate interventions are written to include contact precautions.*	50%

F.8.a.ii: Assesses these data for trends
There has been variability in the compliance data.

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	100%	100%
3.	92%	81%
4.	96%	100%
5.	77%	95%
6.	85%	81%
7.	60%	72%
8.	36%	50%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	100%
3.	100%	75%
4.	100%	100%
5.	100%	100%
6.	100%	100%
7.	80%	75%
8.	40%	25%

F.8.a.iii: Initiates inquiries regarding problematic trends
There has been a trend of increasing number of cases of MRSA, which reflects the community trend of associated MRSA. However, there has been no outbreak at PSH. Contact precautions are being consistently ordered by the physician, but nursing staff is not incorporating these into the WRPs. The Infection Control liaison nurse has been working directly with unit nurses who care for an individual

diagnosed with MRSA. As noted previously, the nurses' plans of care are not consistently incorporated into the finalized WRP due to not using the WaRMSS version of the WRP attachment.

F.8.a.iv: Identifies necessary corrective action
The Nurse Administrator will have the HSS staff ensure that nursing is using the required WaRMSS WRP attachment.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
There has not been enough time to determine if the corrective actions were effective.

A review of the records of 20 individuals diagnosed with MRSA (AKS, CDM, CL, CLS, CLT, CW, DLD, EEE, JEL, JJD, JP, KHC, MG, MGT, MJ, RAS, RB, VFR, YT and ZHO) found that seven were in compliance.

Positive PPD
The DMH IC Positive PPD Audit, based on 100% of individuals in the hospital who have a positive PPD test during the review months (May-October 2008), demonstrated the following:

1.	*Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.*	100%
2.	*All positive PPDs received PA and lateral chest x-ray.*	81%
3.	*All positive PPDs received an evaluation by the Med-Surg Physician.*	94%
4.	*If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.*	N/A
5.	*If LTBI is present, there is a Focus 6 opened.*	86%
6.	*If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.*	17%

7.	*If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.*	22%

F.8.a.ii: Assesses these data for trends

There has been variability in the compliance data.

	Previous period	Current period
Mean compliance rate		
1.	100%	100%
2.	84%	81%
3.	84%	94%
4.	N/A	N/A
5.	Not evaluated	86%
6.	Not evaluated	17%
7.	Not evaluated	22%
Compliance rate in last month of period		
1.	100%	100%
2.	100%	80%
3.	100%	75%
4.	N/A	N/A
5.	Not evaluated	67%
6.	Not evaluated	0%
7.	Not evaluated	0%

F.8.a.iii: Initiates inquiries regarding problematic trends
Items 5-7 are new items being evaluated regarding incorporating LTBI into the WRP.

F.8.a.iv: Identifies necessary corrective action
When implemented, the immunization/PPD team will provide all required immunizations as well as PPDs.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
The Immunization/PPD team will notify the Infection Control Department immediately when an individual has a positive PPD, which will enable the Infection Control liaison nurse to work directly with the WRPTs.

A review of the records of 19 individuals who had a positive PPD (AM, AVM, CDK, CPC, CT, ER, GH, JCM, JDH, JS, LLO, MBG, MFG, MRO, RAW, RLM, RVM, SJP and WM) found that 13 were in compliance.

Refusal of Admitting or Annual Lab Work or Diagnostic Tests
The DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (May-October 2008), demonstrated the following:

1.	*Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control Department.*	27%
2.	*There is a Focus opened for the lab work or PPD refusal.*	28%
3.	*There are appropriate objectives written for the lab work or PPD refusal.*	16%

4.	*There are appropriate interventions written for the lab work or PPD refusal.*	17%

F.8.a.ii: Assesses these data for trends
There have been overall increases in mean compliance rates.

	Previous period	Current period
Mean compliance rate		
1.	22%	27%
2.	5%	28%
3.	6%	16%
4.	12%	17%
Compliance rate in last month of period		
1.	29%	28%
2.	0%	33%
3.	8%	38%
4.	17%	50%

F.8.a.iii: Initiates inquiries regarding problematic trends
WRPTs are not consistently addressing refusals within the WRP. Since the units are not notifying the Infection Control Department, the liaison nurse is not able to provide assistance.

F.8.a.iv: Identifies necessary corrective action
The Infection Control Department notifies the Nursing Coordinator monthly of deficiencies within his/her program regarding PPD tracking forms.

F.8.a.v: Monitors to ensure that appropriate remedies are achieved
Once the immunization/PPD team has been implemented, the Infection Control Department will be consistently alerted when individuals refuse immunizations or PPDs, enabling the infection control liaison nurse to

work with the WRPTs regarding appropriate plans of care.

A review of the records of ten individuals who had refused PPDs (ED, EL, GA, GM, JJH, LAS, MDD, NG, PDH and TMW) found that two were in compliance.

Sexually Transmitted Diseases

The DMH IC Sexually Transmitted Disease (STD) Audit, based on a 100 % sample of individuals in the hospital who tested positive for an STD during the review months (May-October 2008), demonstrated the following:

1.	*Notification by the lab was made to the Infection Control Department of a positive STD.*	100%
2.	*Notification by the lab was made to the unit housing the individual that he/she has a STD.*	100%
3.	*An RPR is ordered during the admission process for each individual.*	N/A
4.	*An HIV antibody test is offered to every individual upon admission.*	N/A
5.	*A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals.*	N/A
6.	*If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.*	N/A
7.	*Focus 6 is opened for an individual testing positive for an STD.*	93%
8.	*Appropriate objective(s) are written.*	57%
9.	*Appropriate interventions are written.*	43%

F.8.a.ii: Assesses these data for trends

Data cannot be compared to the last reporting period as the sample has changed.

		F.8.a.iii: Initiates inquiries regarding problematic trends As noted previously, the nurses' plans of care are not consistently incorporated into the finalized WRPs due to not using the WaRMSS version of the WRP attachment. F.8.a.iv: Identifies necessary corrective action The Nurse Administrator will have the HSS staff ensure that nursing is using the required WaRMSS WRP attachment. F.8.a.v: Monitors to ensure that appropriate remedies are achieved There has not been enough time to determine if the corrective actions were effective, but PSH will continue to monitor these items. A review of the records of nine individuals diagnosed with an STD (AP, CS, DLC, EKS, FB, GH, JDH, TDR and YMV) found that five were in compliance. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** See F.8.a.i. **Compliance:** Substantial.

		Current recommendation: Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Continue current practices. • Continue to monitor this requirement. **Findings:** See F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.

F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH's Infection Control Committee meeting minutes for this review period validate that the IC Department continuously monitors actions and recommendations regarding problematic trends. See also F.8.a.i. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** A review of supporting documentation found that IC issues have been discussed and plans of action implemented and integrated into the different departments and into the facility's Quality Improvement Committee/Enhancement Plan Committee. **Compliance:** Substantial. **Current recommendation**: Continue to monitor this requirement.

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. Amy Santimalapong, DDS, Chief Dentist 2. Kathryn Smith, RN, Nurse Auditor Reviewed: 1. PSH's progress report and data 2. Dental Appointment logs 3. Medical records for the following 119 individuals: ABR, ADH, AFF, AG, AJP, AK, AM, APL, AS, AW, BCT, BEM, BK, BKS, BSG, BWS, CB, CBH, CDK, CJB, CLB, CMT, CT, CW, DAL, DDA, DET, DMD, DO, DP, DTR, EB, EG, EH, EIG, ELJ, EM, FEG, GA, GDC, GFB, GJW, GL, GLP, GLW, GST, HG, HP, JAC, JAM, JB, JC, JCL, JD, JEB, JH, JH-2, JKL, JL, JLG, JLZ, JMR, JTG, JUH, KC, KEO, KET, KG, KJC, KT, KWY, LAG, LAL, LJH, LLO, LS, MAH, MAK, MEM, MG, MGT, MJB, MJC, MLS, MS, MW, NGG, ORL, PF, PJW, RAB, RAG, REJ, RG, RJ, RJL, RJS, ROS, RR, RR-2, RRI, RS, RSO, RVB, RYB, SB, SDH, SH, SRF, TJ, TMP, VB, WAL, WC, WJB, WN, WR, YP and YR
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** At the time of this review, PSH has one Chief Dentist, two staff Dentists, two Registered Dental Assistants and two Dental Assistants. The number of dental staff has remained unchanged since the last reporting period.

		Compliance: Partial. **Current recommendation**: Continue current practice.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Develop a system to track timely follow-up care for individuals with problems identified in admission and annual exams. **Findings:** PSH has received the new dental software package. However, it has not yet been installed. PSH's progress report indicated that barriers associated with hardware and the environment have delayed the installation. It is anticipated to be installed by the next review period. **Recommendation 2, June 2008:** Continue to monitor this requirement. **Findings:** PSH's data from the DMH Dental Services Audit Form, based on an average sample of 86% of individuals scheduled for a comprehensive dental exam during the review month (May-October 2008) is summarized below:

1.	*Comprehensive dental exam was completed.*	72%
1.a	*A comprehensive dental exam was completed and included oral hard and soft tissue exam.*	99%

1.b	*A comprehensive dental exam was completed and included review of x-rays.*	99%
1.c	*A comprehensive dental exam was completed and included periodontal exam.*	99%
1.d	*A comprehensive dental exam was completed and included review of prosthetics, if present*	99%

The population used for item 1 is scheduled dental exams and the population used for items 1.a–1.d is completed dental exams.

PSH's data analysis is presented below. No comparison data for sub-items was provided.

	Previous period	Current period
Mean compliance rate		
1.	39%	72%
Compliance rate in last month of period		
1.	68%	43%

PSH indicated that low compliance scores for August through October were due to dental staff medical leaves/vacations. No plan of correction was provided by PSH.

A review of the records of 28 individuals admitted during the review period (ADH, CDK, CJB, CW, DET, DMD, DTR, EB, EIG, ELJ, EM, GFB, GL, GLP, HP, JCL, JKL, JTG, LLO, MJC, MLS, PF, RG, RR, RSO, SB, SDH and WAL) found that 25 were in compliance with having a comprehensive dental exam.

Additional data from the DMH Dental Services Audit Form, based on an average sample of 17% of individuals who have been in the hospital for 90 days during the review period (May-October 2008), is summarized

below:

1.b	*If admission examination date was 90 days or less*	81%

PSH data analysis demonstrated a slight decrease in compliance:

	Previous period	Current period
Mean compliance rate		
1.	88%	81%
Compliance rate in last month of period		
1.	100%	100%

A review of the records of 28 individuals admitted during the review period (ADH, CDK, CJB, CW, DET, DMD, DTR, EB, EIG, ELJ, EM, GFB, GL, GLP, HP, JCL, JKL, JTG, LLO, MJC, MLS, PF, RG, RR, RSO, SB, SDH and WAL) found that 27 were in compliance with timeliness of the admission dental exam.

PSH's data from the DMH Dental Services Audit Form, based on an average sample of 34% of individuals due for annual routine dental examinations during the review months (May-October 2008) is summarized below:

1.c	*Annual date of examination was within anniversary month of admission*	64%

PSH's data analysis is presented below demonstrating an increase in compliance.

	Previous period	Current period
Mean compliance rate		
1.	54%	64%
Compliance rate in last month of period		
1.	95%	65%

No barriers to compliance or plan of correction were provided.

A review of the records of 41 individuals due for an annual dental exam during the review period (AFF, AJP, AS, BCT, BK, BKS, CBH, CMT, DAL, EG, EH, GA, GJW, HG, JAM, JB, JD, JH, JH-2, JMR, KC, KJC, KT, LJH, LS, MAH, MG, MGT, MS, MW, RAG, RJ, RJS, RRI, RVB, SH, SRF, WJB, WN, YP and YR) found that 23 were in compliance.

PSH used the DMH Dental Services Audit Form, based on an average sample of 39% of individuals with identified dental problems on admission or annual examination and 100% of individuals with identified problems during their hospital stay other than on admission or annual examination for May-October 2008 to assess compliance. The data are summarized below:

1.d	*Individuals with identified problems on admission or annual examination receive follow-up care, as indicated, in a timely manner*	100%

No comparison data was collected for the last reporting period.

A review of the records of 28 individuals admitted during the review period (ADH, CDK, CJB, CW, DET, DMD, DTR, EB, EIG, ELJ, EM, GFB, GL, GLP, HP, JCL, JKL, JTG, LLO, MJC, MLS, PF, RG, RR, RSO, SB, SDH and WAL) found that 27 were in compliance with timely receipt of

		follow-up care. The data regarding item 1.e (not noted above), *individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner*, could not be interpreted since the facility used as its sample all individuals with identified dental problems on admission or annual examination. **Current recommendations**: 1. Provide comparison data for sub-items, barriers to compliance and plans of corrections as appropriate. 2. Modify population for item 1.e, *individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner* to accurately reflect data. 3. Continue to monitor this requirement.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH's data from the DMH Dental Services Audit Form, based on an average sample of 22% of individuals scheduled for follow-up dental care during the review months (May-October 2008), is summarized below: 2. *Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.* 69% 2.a *The current status* 75%

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<tr><td>2.b</td><td>Findings of the examination</td><td>70%</td></tr>
<tr><td>2.c</td><td>Plan of care</td><td>74%</td></tr>
<tr><td>2.d</td><td>The plans of care are consistent with examination findings</td><td>67%</td></tr>
</table>

No comparison data for sub-items were provided.

<table>
<tr><td></td><td>Previous period</td><td>Current period</td></tr>
<tr><td colspan="3">Mean compliance rate</td></tr>
<tr><td>2.</td><td>75%</td><td>69%</td></tr>
<tr><td colspan="3">Compliance rate in last month of period</td></tr>
<tr><td>2.</td><td>67%</td><td>87%</td></tr>
</table>

PSH indicated that the quality of the dental notes is impacted by the number of individuals that are seen in a day. No plan of correction was provided.

A review of dental documentation for 40 individuals (ADH, CDK, CJB, CMT, CW, DAL, DET, DTR, EB, EIG, ELJ, EM, GL, JAM, JB, JCL, JD, JH, JMR, KJC, KT, LJH, LLO, MAH, MG, MGT, MJC, MLS, PF, RG, RJS, RR, RVB, SB, SH, SRF, WAL, WJB, WN and YP) found that 32 were in compliance.

Current recommendations:
1. Provide comparison data for sub-items, barriers to compliance and plans of corrections as appropriate.
2. Continue to monitor this requirement.
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<tr>
<td>F.9.b.iii</td>
<td>use of preventive and restorative care whenever possible; and</td>
<td>Current findings on previous recommendation:

Recommendation, June 2008:
Continue to monitor this requirement.</td>
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</table>

		Findings: PSH's data for this requirement could not be interpreted. Data regarding preventative and restorative care was combined and not divided as in the current DMH Dental Services Audit form. In addition, the dental auditor stated that there is not a system in place at this time that tracks preventative and restorative care provided. Dental staff were unsure at the time of this review if the new dental software could be used to track care provided. **Current recommendations**: 1. Ensure that the most current monitoring tool is used for data collection for the next review. 2. Develop and implement a system to track preventative and restorative care provided. 3. Continue to monitor this requirement.
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Increase audited sample size. **Findings:** PSH's data indicated that the sample size for this review period was 100%. **Recommendation 2, June 2008:** Continue to monitor this requirement. **Findings:** PSH's data from the DMH Dental Services Audit For, based on a 100% sample of individuals who had tooth extractions during the review months (May-October 2008), is as follows:

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<tr><td>4.a</td><td>Periodontal conditions, requirement for denture construction, non-restorable tooth, or severe decay</td><td>98%</td></tr>
</table>

PSH's data analysis indicated that Item 4 remained basically unchanged from 100% in April to 98% in October. Mean data were not collected for the last reporting period.

A review of 29 individuals that had tooth extractions during the review period (APL, AW, BSG, BWS, CB, CLB, CT, CW, DO, GDC, GST, HP, JC, JEB, JLG, JLZ, LLO, MJB, MS, NGG, ORL, PF, PJW, REJ, RJL, RR, RSO, SRF and WR) found that all were in compliance.

Current recommendation:
Continue current practice.
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<tr>
<td>F.9.c</td>
<td>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.</td>
<td>
Current findings on previous recommendation:

Recommendation, June 2008:
Continue to monitor this requirement.

Findings:
PSH's data from the DMH Dental Services Audit Form, based on an average sample of 22% of individuals who received comprehensive dental examinations or follow-up dental care during the review months (May-October 2008), is summarized below:
<table>
<tr><td>5.</td><td>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.</td><td>83%</td></tr>
<tr><td>5.a</td><td>Physical health impact on dental service</td><td>91%</td></tr>
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5.b	*Medications*	91%
5.c	*Allergies that impact on dental service*	91%
5.d	*General condition of current oral environment*	86%
5.e	*When individual compliant is noted within the findings, there is documentation related to exam results*	93%

PSH data analysis demonstrated an increase in compliance.

	Previous period	Current period
Mean compliance rate		
5.	48%	83%
Compliance rate in last month of period		
5.	56%	96%

A review of dental documentation for 40 individuals (ADH, CDK, CJB, CMT, CW, DAL, DET, DTR, EB, EIG, ELJ, EM, GL, JAM, JB, JCL, JD, JH, JMR, KJC, KT, LJH, LLO, MAH, MG, MGT, MJC, MLS, PF, RG, RJS, RR, RVB, SB, SH, SRF, WAL, WJB, WN and YP) found compliance in 39 records. The primary reason for compliance rates below 90% appears to be dental staff leaves.

Compliance:
Partial.

Current recommendation:
Continue current practice.

F.9.d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Implement collection of data regarding dental refusals, addressing

compliance.

this requirement.

- Continue to monitor this requirement.

Findings:
PSH's data from the DMH Dental Services Audit Form based on a 100% sample of individuals scheduled for a dental appointment during the review months (May-October 2008) indicated the following:

6.a	*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.*	93%

PSH data analysis demonstrated an increase in compliance.

	Previous period	Current period
Mean compliance rate		
6.a	57%	93%
Compliance rate in last month of period		
6.a	52%	94%

A review of the dental appointment logs for August and September 2008 found that the majority of missed appointments were due to refusals, which are covered in the following cell (F.9.e) and that there was only one canceled appointment due to a staffing issue and none related to transportation issues. However, this information conflicts with information provided to the court monitor for cell C.2.r.

Compliance:
Partial.

		Current recommendation: Continue to monitor this requirement.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	**Current findings on previous recommendation:** **Recommendation, June 2008:** See F.9.d. **Findings:** See C.2.l. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. PSH has made significant improvement regarding the documentation of specific behaviors indicating an imminent danger to self or others that warranted the use of seclusion/restraints. 2. PSH has made progress in the WRP documentation addressing behaviors related to objectives and interventions. 3. PSH has maintained substantial compliance regarding restraint or seclusion not being used as elements of behavioral interventions.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Alan Hild, Program I Director 2. Arthur Morales, Acting Program V Director 3. Charles Allen, Nursing Coordinator 4. Darold Dahse, Nursing Coordinator 5. Diane White, Nursing Coordinator 6. Don Clutter, Nursing Coordinator 7. Gari-Lyn Richardson, Standards Compliance Director 8. Giancarlo Gonzalez, Program VIII Director 9. Ginny Gibialante, Program IV Director 10. Harry Oreol, Program VI Director 11. James Birks, Nursing Coordinator 12. Jim Pollard, Program Director 13. Kathy Wood, Nursing Coordinator 14. Lidia Lau, RN, ACNS 15. Peggy Thomas, Program VII Director 16. Randy Bohlmann, Nursing Coordinator Standards Compliance 17. Rebecca Kornbluh, MD, Chief of Professional Education 18. Robert Short, Psychiatric Technician Auditor 19. Sidney Leggs, Acting Nursing Coordinator

		20. Tod Heywood, Unit Supervisor 21. W. Harris, MD, Senior Psychiatrist 22. Wadsworth Murad, MD, Acting Medical Director Reviewed: 1. PSH's progress report and data 2. PSH's training rosters for Review of AD 15.14; Prevention and Management of Assaultive Behavior (PMAB); Principles of Medications; and Prevention and Management of Seclusion or Restraint Training 3. AD 15.14, Seclusion or Restraint 4. Medical records for the following 35 individuals: AAB, AG, AGW, AKR, AM, BRA, CB, CCS, CLB, CW, DBP, DLR, EA, FAR, GWD, HRB, JAA, KAF, KBS, KLK, LD, LDS, LEF, NCC, NMK, RK, RTH, SA, SAB, SAR, SH, SLK, VLM, VMC and WMM Observation: Use of the MedSelect System
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** No incidents of prone restraints, containment or transportation were found during this review. PSH recently revised AD 15.14 to include documentation of clinical justification when less restrictive interventions(s) are not used and of physician/psychiatrist face-to-face evaluation within one hour of initiation of restraint or seclusion and every four hours thereafter.

		Other findings: As of October 2008, PSH's training records verified that 98% of staff had received training on Policy and Procedure for Use of Seclusion, Restraint, Psychiatric PRN Medications, Stat Medications and Prohibition of Prone Containment and Transportation. As PSH has filled staffing vacancies, which has increased the number of staff required to complete this training, compliance has remained high. **Compliance:** Substantial. **Current recommendation**: Continue current practice.
H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Streamline documentation system for seclusion and restraints. **Findings:** No information was provided relative to this recommendation. **Recommendation 2, June 2008:** Continue to monitor this requirement. **Findings:** The facility reported data from the DMH Seclusion/Restraint Audit based on a 100% sample (eight episodes) of seclusion episodes for May-October 2008. The table below summarizes PSH's data:

2.	*Restraints and seclusion are used in a documented manner.*	86%
2.a	*The IDN described specific behavior that was imminently dangerous to self or others, and*	86%
2.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	100%
3.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	86%
4.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	71%
4.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	100%
4.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	71%

Because PSH began using the DMH Seclusion/Restraint Audit in April 2008, mean compliance rates for the prior review period are not available. In this section of this report, comparative data will necessarily focus on the last month of the prior review period (April 2008) and the last month of the current review period (October 2008). This applies to all subsequent cells in this section.

PSH's data analysis demonstrated an increase in compliance with the exception of item 2.a. One incident in October 2008 (the last month of the current review period) resulted in the data being less than 100% across the board.

	Previous period	Current period
Compliance rate in last month of period		
2.	0%	50%
2.a	100%	50%
2.b	0%	100%
3.	0%	50%
4.	0%	50%
4.a	0%	100%
4.b	0%	50%

PSH's plan of correction includes implementing training on Therapeutic Strategies and Interventions (TSI), which will replace the current Prevention and Management of Assaultive Behavior (PMAB) training beginning in 2009. The TSI training emphasizes assessment and documentation of preventive measures and implementation of restrictive interventions. Training for trainers will be initiated state-wide in January 2009 and new employee training will begin in February 2009. Current employee training will begin in February/March 2009 as part of the annual required training.

The facility reported data from the DMH Seclusion/Restraint Audit based on a 97% sample of restraint episodes for May-October 2008. The table below summarizes PSH's data:

2.	*Restraints and seclusion are used in a documented manner.*	83%
2.a	*The IDN described specific behavior that was imminently dangerous to self or others, and*	90%
2.b	*The Physician's Order described specific behavior that was imminently dangerous to self or others.*	87%

3.	*Restraints and seclusion are used only when the individual posed an imminent danger to self or others.*	92%
4.	*Restraints and seclusion are used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.*	82%
4.a	*The IDN described specific, less-restrictive interventions that were tried prior to the use of restraints or seclusion, or there is clinical justification when less-restrictive interventions were not used.*	87%
4.b	*The IDN described the individual's specific response to each intervention used, or there is clinical justification when less- restrictive interventions were not used.*	85%

PSH data analysis demonstrated several increases in compliance.

	Previous period	Current period
Compliance rate in last month of period		
2.	92%	89%
2.a	97%	98%
2.b	93%	91%
3.	96%	98%
4.	78%	98%
4.a	90%	98%
4.b	79%	98%

A review of 47 incidents of restraint and seclusion for 24 individuals (AAB, AG, AGW, AM, BRA, CCS, CLB, CW, EA, FAR, GWD, HRB, KLK, LDS, LEF, NMK, RK, SAB, SAR, SH, SLK, VLM, VMC and WMM) found that 32 described behaviors indicating that the use of seclusion/

		restraint was in response to behaviors that demonstrated an imminent danger to self or others. The physician orders for 39 incidents included specific behaviors and 42 incidents included the use of less restrictive measures. **Current recommendation**: Continue to monitor this requirement.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** The facility reported data from the DMH Seclusion/Restraint Audit based on a 100% sample of seclusion episodes for May-October 2008. The table below summarizes PSH's data:

5.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	86%
5a.	*There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in seclusion/restraints.*	86%
5b.	*There is a linked objective.*	100%
5c.	*There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion/restraints.*	100%
6.	*Restraints and seclusion are not used as punishment.*	29%
6.a	*The staff did not use restraints or seclusion in an abusive manner.*	86%
6.b	*The staff did not keep the individual in restraints or seclusion even when the individual was calm.*	29%

6.c	*The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	86%
6.d	*The staff did not use restraints or seclusion as coercion.*	86%
7.	*Restraints and seclusion are not used for the convenience of staff.*	0%
7.a	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.*	0%

Comparison data showed improvement except for items 6.a, 6.c and 6.d:

	Previous period	Current period
Compliance rate in last month of period		
5.	0%	50%
5.a	0%	50%
5.b	0%	100%
5.c	0%	100%
6.	0%	50%
6.a	100%	50%
6.b	0%	50%
6.c	100%	50%
6.d	100%	50%
7.	0%	0%

No barriers to compliance were provided. See H.2.a for PSH's plan of correction.

A review of four incidents of seclusion for four individuals (EA, FAR, SLK and VMC) found that the WRPs of three individuals contained documentation addressing behaviors, objectives and interventions and documentation in one incident indicated that the individual was released when calm.

The facility reported data from the DMH Seclusion/Restraint Audit based on a 97% average sample of restraint episodes for May-October 2008. The table below summarizes PSH's data:

5.	*Restraints and seclusion are not used in the absence of, or as an alternative to, active treatment.*	82%
5a.	*There is a Focus of Hospitalization that targets the behavior that required the individuals to be placed in seclusion/restraints.*	87%
5b.	*There is a linked objective.*	90%
5c.	*There is a linked intervention (any formal group, individual therapy, or behavioral intervention) for the target behavior that required the individual to be placed in seclusion/restraints.*	89%
6.	*Restraints and seclusion are not used as punishment.*	46%
6.a	*The staff did not use restraints or seclusion in an abusive manner.*	98%
6.b	*The staff did not keep the individual in restraints or seclusion even when the individual was calm.*	47%
6.c	*The staff did not use restraints or seclusion in a manner to show a power differential that exists between staff and the individual.*	96%
6.d	*The staff did not use restraints or seclusion as coercion.*	98%
7.	*Restraints and seclusion are not used for the convenience of staff.*	21%

7.a	*Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (MSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.*	21%

Comparison data demonstrated several modest increases in compliance since the last review:

	Previous period	Current period
Compliance rate in last month of period		
5.	85%	82%
5.a	85%	91%
5.b	89%	98%
5.c	91%	90%
6.	42%	57%
6.a	95%	98%
6.b	48%	57%
6.c	90%	98%
6.d	95%	98%
7.	0%	4%

PSH indicated that low compliance for Items 6 and 6.b was due to staff not releasing the individual from restraint when the documentation noted the individual was calm for more than 15 minutes. Inconsistent auditing criteria was cited as the reason for low compliance scores for item 7. Clarification was given in July 2008.

A review of 43 incidents of restraint for 21 individuals (AAB, AG, AGW, AM, BRA, CCS, CLB, CW, GWD, HRB, KLK, LDS, LEF, NMK, RK, SAB,

		SAR, SH, VLM, VMC and WMM) found that the WRPs of 16 individuals contained documentation addressing behaviors, objectives and interventions and documentation in 18 incidents indicated that the individual was released when calm. **Current recommendation**: Continue to monitor this requirement.
H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** 8. *Behavioral interventions, which include Positive Behavior Support Plans, are based on a positive behavior support model, and do not include the use of aversive or punishment contingencies.* 100% Comparison data showed continued maintenance of compliance since the last review. Review of PBS plans/Behavioral Guidelines for six individuals (BRA, KLK, NMK, SAR, VMC and WMM) found that all were in compliance. **Current recommendation**: Continue current practice.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement.

Findings:
PSH's data from the DMH Seclusion/Restraint Audit based on a 100% sample of seclusion episodes for May-October 2008 is summarized in the table below:

9.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	29%
9.a	*The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.*	29%
9.b	*The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.*	29%
9.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	57%
9.d	*The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.*	57%
9.e	*The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.*	57%
9.f	*The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.*	57%
9.g	*The individual did not continue to be in restraints or seclusion because he/she was unable to say he/she is sorry for his/her actions.*	57%

Comparison data demonstrated an increase in compliance since the last

review:

	Previous period	Current period
Compliance rate in last month of period		
9.	0%	50%
9.a	0%	50%
9.b	0%	50%
9.c	0%	100%
9.d	0%	100%
9.e	0%	100%
9.f	0%	100%
9.g	0%	100%

The low compliance scores were attributed to documentation issues and staff not appropriately releasing individuals from seclusion. See H.2.a for PSH's plan of correction. See also H.2.b for this monitor's findings

PSH's data from the DMH Seclusion/Restraint Audit based on a 97% sample of restraint episodes for May-October 2008 is summarized in the table below:

9.	*Restraints and seclusion are terminated as soon as the individual is no longer an imminent danger to self or others.*	43%
9.a	*The individual was released from restraints or seclusion as soon as the violent or dangerous behavior that created the emergency was no longer displayed or met the release criteria on the restraints or seclusion order.*	47%
9.b	*The individual did not continue to be in restraints or seclusion after remaining calm for 15 minutes.*	47%

9.c	*The individual did not continue to be in restraints or seclusion because he/she was unable to contract for safety.*	79%
9.d	*The individual did not continue to be in restraints or seclusion because he/she was unable to agree to cease using offensive language.*	80%
9.e	*The individual did not continue to be in restraints or seclusion because he/she did not cease making verbal threats.*	78%
9.f	*The individual did not continue to be in restraints or seclusion because he/she was not able to say he/she recognizes what behavior prompted the restraints or seclusion episode.*	80%
9.g	*The individual did not continue to be in restraints or seclusion because he/she was unable to say he/she is sorry for his/her actions.*	82%

Comparison data showed an increase in compliance since the last review period:

	Previous period	Current period
Compliance rate in last month of period		
9.	41%	57%
9.a	44%	57%
9.b	44%	59%
9.c	56%	98%
9.d	59%	98%
9.e	61%	96%
9.f	60%	93%
9.g	63%	100%

		See H.2.a for plan of action and H.2.b for this monitor's findings **Current recommendation**: Continue to monitor this requirement.
H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH's data from the DMH Seclusion/Restraint Audit, based on a 100% sample of restraint episodes for May-October 2008, is summarized in the table below: 10. *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.* 86% 10.a *The order was obtained within 15 minutes from the initiation of restraints or seclusion.* 100% 10.b *The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.* 83% 10.c *The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.* 100% PSH's comparison data is as follows:

	Previous period	Current period
Compliance rate in last month of period		
10.	100%	100%
10.a	100%	100%
10.b	100%	100%
10.c	100%	100%

A review of four incidents of seclusion for four individuals (EA, FAR, SLK and VMC) found that all were in compliance.

PSH's data from the DMH Seclusion/Restraint Audit, based on a 97% sample of restraint episodes for May-October 2008, is summarized in the table below:

10.	*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.*	79%
10.a	*The order was obtained within 15 minutes from the initiation of restraints or seclusion.*	91%
10.b	*The RN conducted an assessment within 15 minutes of the initiation of restraints or seclusion, and documented in the IDN.*	90%
10.c	*The Physician conducted a face-to-face evaluation of the individual in restraints or seclusion within one hour from the initiation of restraints or seclusion and documented in the Physician's Progress Note.*	91%

PSH's comparison data is as follows:

	Previous period	Current period
Compliance rate in last month of period		
10.	90%	83%
10.a	96%	93%
10.b	98%	93%
10.c	92%	94%

Inconsistency was reported as the primary barrier to compliance. See H.2.a for plan of action.

A review of 43 incidents of restraint for 21 individuals (AAB, AG, AGW, AM, BRA, CCS, CLB, CW, GWD, HRB, KLK, LDS, LEF, NMK, RK, SAB, SAR, SH, VLM, VMC and WMM) found that 39 were in compliance.

Prevention and Management of Seclusion or Restraint Training

	May	Jun	Jul	Aug	Sept	Oct
N	1247	1249	1252	1268	1272	1279
n	976	1023	1045	1074	1111	1133
%C	78	82	84	85	87	89

N = total number of nursing staff who monitor individuals while in restraints or seclusion
n = total number of nursing staff who completed and passed the training

PSH's training compliance was 81% in April 2008 and 89% in October 2008.

Review of PSH's training rosters verified that 89% of nursing staff have completed the Prevention and Management of Seclusion or Restraint Training.

		Compliance: Partial. **Current recommendation**: Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendations:** **Recommendations 1 and 2, June 2008:** • Present data regarding this requirement. • Continue to monitor this requirement. **Findings:** PSH has implemented the MedSelect System and the MedOrder phase of the system has been implemented on all units in the East Compound: EB, U and 70 Buildings. Hospital-wide implementation is projected to be completed by the end of January 2009. At that time, most of the administered medications will be electronically recorded and monitored by the Pharmacy Department. Exceptions to this include some floor stock items such as vitamins, over-the-counter medications and treatments such as inhalers, eye drops and ointments. After the implementation of unit dose hospital-wide, the Pharmacy plans to include the above exceptions to be signed off on the MedSelect system. Full implementation of this system is expected by the end of June 2009. Orders that have been reviewed and validated by the Pharmacist will appear on the unit MedSelect computer for administering to the individuals. Color coding is used to identify the time a dose is to be administered. The medication room nurse will review the individual's medication profile to ensure the right medication doses are scheduled at the right time. The system records the medication name, dose, and time of administration and the nurse who administered the medications.

		This system allows the Pharmacy to generate reports by filtering the psychotropic medications. However, since some medications have dual indications, the report may not be consistently accurate. Pharmacy will be working to develop an accurate method to report the use of psychotropic PRN or Stat medication by February 2009. **Other findings:** See F.3.a.i. **Compliance:** Partial. **Current recommendations**: 1. Continue to implement the MedSelect System as outlined. 2. Continue to monitor this requirement.
H.5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service 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 recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** There were no instances of an individual placed in seclusion more than three times in a 30-day period during this review period. PSH reported the following data from the DMH Restraint Audit based on a 100% sample of individuals who were placed in restraint four or more times in 30 days for May-October 2008. 13. *Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week* — 4%

	period, and modification of therapeutic and rehabilitation service plans, as appropriate	
13.a	*The review was held within three business days for any individual who had four or more episodes of Seclusion or Restraints within the last 30 days*	22%
13.b	*The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done*	20%
13.c	*If the team decided to revise the WRP, a statement as to what part of the WRP was revised, OR if the team decided not to revise the WRP, a brief clinical justification as to why, was documented in the Present Status in the Case Formulation Section of the WRP*	9%

PSH's comparison data demonstrated decreases in compliance from the last review period:

	Previous period	Current period
Compliance rate in last month of period		
13.	20%	0%
13.a	40%	0%
13.b	50%	0%
13.c	0%	N/A

PSH identified the lack of a systematic process to follow up with the WRPTs as a barrier to compliance. PSH's plan of correction included sending duplicate notification to Program Management when there is a notification of a trigger by Standards Compliance to the respective WRPT. Follow-up will be done by the Program to ensure compliance. Also, the results of the audit data will be shared with the appropriate WRPTs. In addition, with the implementation of Risk Management

		system, the Program Review Committee will also follow up on this process. A review of the records of 12 individuals who met the trigger criteria for restraint during the review period (AAB, AG, AGW, BRA, GWD, KLK, LDS, NMK, SAR, SH, VMC and WMM) found three to be in compliance. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** See F.1.b. **Current recommendations**: 1. Same as in F.1.b. 2. Continue to monitor this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized	**Current findings on previous recommendation:**

	behaviors.	**Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** See F.1.b. **Current recommendations**: 1. Same as F.1.b. 2. Continue to monitor this requirement.
H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** PSH provided the following Medication Variance auditing data, which indicates 99% mean compliance with the time-limiting of PRN orders: **MVR Data** 5-08 / 6-08 / 7-08 / 8-08 / 9-08 / 10-08 / Mean N: 786 / 756 / 740 / 731 / 830 / 811 / 776 n: 4 / 5 / 2 / 0 / 0 / 0 / 2 %C [calculated as 1-(n/N)]: 99 / 99 / 99 / 100 / 100 / 100 / 99 N=total PRN orders written n=number of PRN orders written for greater than 15 days A review of 50 physician orders for PRN medications for 15 individuals (AKR, BRA, CB, CLB, DBP, DLR, JAA, KAF, KBS, LD, NCC, RTH, SA, SLK and VMC) found that all were in compliance.

		Current recommendation: Continue current practice.
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** See F.3.a.iii for PSH's data and this monitor's findings. **Current recommendation**: See F.3.a.iii.
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Same as in D.1.f, F.1.b and H.6.a. **Findings:** Same as in D.1.f, F.1.b and H.6.a **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** See F.3.h.i and F.3.h.ii for training data and this monitor's findings.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
H.8	Each State hospital shall:	**Compliance:** Not applicable.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** There was no use of side rails at PSH during this review period. **Current recommendation**: Continue to monitor this requirement.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to monitor this requirement. **Findings:** There was no use of side rails at PSH during this review period. In the event that an individual would need of side rails, the PSH Utilization Review Nurse would be responsible for reviewing the individual's plan of care to ensure that all documentation requirements are met. **Current recommendation**: Continue to monitor this requirement.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. The Incident Review Committee is identifying deficiencies in and posing questions about investigations. Corrections, revisions and answers are tracked through the IRC minutes. 2. The IRC is identifying the need for programmatic measures to address issues raised in investigations and following the implementation of these measures. 3. The SIR database has been expanded to include the names of staff members. 4. The facility has taken measures to correct data entry errors in the Record Management System and is working with the vendor and the other facilities to address the system's ability to produce trending and pattern reports. 5. PSH has implemented the incident-related portion of the Risk Management System envisioned in SO 262. Program Review Committees have been functioning since October 2008. After a trial of separate PSSC and Enhanced Review Committee meetings, the facility has blended the two meetings and finds that this is more efficient and produces better results for the individuals reviewed. 6. The Mortality Interdisciplinary Review Committee began functioning in March 2008. It has identified gaps in the provision of nursing care in several cases and made recommendations to remedy these. 7. The facility has trained Program Directors, Department Chairs and others in leadership positions in the Plato information management system, giving the user real-time access to trigger information

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. G. Richardson, Director, Standards Compliance 2. J. Olive, Supervising Special Investigator 3. J. Powell, Chief of Police Reviewed: 1. 22 investigation reports, including five death investigation reports 2. 10 Headquarters Reportable Briefs 3. Incident Review Committee minutes for August through October 4. Lists of incidents, May-October, compiled from SIR database 5. Lists of incidents, May-October, compiled from the Records Management System 6. Mortality Interdisciplinary Review Committee minutes for the deaths of seven individuals 7. AD 15.13, Patient Abuse and Neglect 8. Clinical records of 15 individuals for signature on rights acknowledgement form
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Revise AD 15.13 as recommended in I.1.a.v [of PSH Report 4].

		Findings: AD 15.13 has been revised to state that the failure to report suspected abuse and neglect will result in progressive corrective or disciplinary action. **Other findings:** There is evidence in the Incident Review Committee (IRC) minutes that the committee is identifying instances in which employees fail to report allegations of abuse/neglect. For example, the August 7 IRC minutes indicate that staff member AD failed to report an allegation of abuse. Subsequent IRC minutes state that the employee received a letter of warning regarding the failure to report. The September 23 IRC minutes confirm that a social worker who failed to report an allegation was verbally counseled. **Current recommendation**: Continue current practice.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice while providing close supervision of investigations and final reports to detect and correct deficiencies. **Findings:** The minutes of the IRC document instances in which investigations have been sent back to the Office of the Special Investigator for further work when the committee requested clarification or additional interviews. For example, the minutes of August 7, 2008 show the OSI returning with an expanded investigation (additional interviews) of an allegation of physical abuse (choking) as requested by the IRC in an earlier meeting. See also I.1.b.iv.3 for additional examples.

		Current recommendation: See recommendations in subsequent cells.
I.1.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, June 2008:** Implement the plan to have the Clinical Administrator make the decision whether to remove a staff member named in an allegation of wrongdoing. **Findings:** The policy regarding removing staff members named in allegations was clarified in an October 14 memo to the Program Directors. The policy requires Program Directors to determine whether to remove a staff member alleged to have physically abused an individual to a non-patient-care area pending the results of the investigation. If the decision is to not remove the named staff, then the decision must be reviewed by the Clinical Administrator. This policy clarification is not consistent with AD 15.13, Patient Abuse and Neglect. **Recommendation 2, June 2008:** Document in the investigation report the decision of the Clinical Administrator. **Findings:** The mid-October date of the memo referenced above was too recent for the new procedure to be reflected in the investigation reports reviewed. **Recommendation 3, June 2008:** IRC should review the sexual abuse incident [described in PSH Report 4] and determine if the named staff member was removed from contact with individuals. If not, determine what went wrong and take

		appropriate remedial action. **Findings:** The facility reports that the named staff member was removed from all contact with individuals and reassigned to a work area outside the security compound. **Other findings:** Ten of the 11 relevant investigation reports reviewed addressed the question of whether the staff member was reassigned. Reassignment pending the conclusion of the investigation occurred in six of the 11 cases. **Current recommendation**: Document in investigation reports the Clinical Administrator's agreement or disagreement with the decision not to remove a named staff member pending the results of an abuse investigation.
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** As demonstrated below, review of the personnel records of 12 staff members indicates that all but one have completed abuse/neglect training within the last year. **Other findings:**

Staff member*	Date of hire	Date of background clearance	Date Mandatory Reporter signed	Date of most recent A/N training
_ R	12/2/96	1/21/97	12/2/96	2/19/08
_ P	5/1/97	4/15/97	5/1/97	10/23/08
_ W	3/2/99	1/22/99	3/2/99	11/19/08
_ B	7/3/00	6/28/00	7/3/00	3/20/08
_ H	10/15/01	5/4/01	10/15/01	8/14/07
_ R	9/2/02	8/17/02	9/2/02	6/17/08
_ P	8/18/03	7/29/03	8/18/03	3/18/08
_ A	2/1/05	11/30/04	2/1/05	4/22/08
_ N	4/18/05	2/8/05	4/8/05	9/15/08
_ B	7/3/06	5/31/06	7/3/06	11/7/08
_ M	3/1/08	1/11/08	3/1/08	3/6/08
_ P	6/2/08	4/18/08	6/2/08	6/6/08

*Only last initials are provided to protect confidentiality.

Current recommendation:
Continue current practice.

I.1.a.v	notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Reconsider revising draft AD 15.13 to state affirmatively that the failure to report an allegation/incident of abuse or neglect will result in corrective or disciplinary action. **Findings:** This recommendation was implemented with the revision of AD 15.13 effective 5/1/08, which states that the "failure to report incidents of suspected abuse or neglect will result in progressive corrective or disciplinary action."

		Other findings: Review of the personnel records of 12 staff members reveals that each had signed the mandatory reporter acknowledgment form on or prior to the date of hire. See I.1.a.i for the facility's attention to identifying failures to report incidents. **Current recommendation**: Continue current practice.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Take additional measures to ensure that rights and responsibilities are discussed with individuals at annual WRPCs and ask individuals to sign the form at that time. **Findings:** Review of the rights and responsibility forms for 15 randomly selected individuals on five units found that eight individuals (53%) had not signed the form in the last year.

Individual	Date of most recent signing
KK	12/1/08
PS	11/6/08
WS	11/5/08
FM	10/6/08
DM	9/12/08
NB	4/10/08
EH	2/27/08
MD	4/5/07
KM	2/13/07
RA	9/18/06

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<tr><td>Individual</td><td>Date of most recent signing</td></tr>
<tr><td>WI</td><td>5/25/06</td></tr>
<tr><td>CD</td><td>9/25/05</td></tr>
<tr><td>JM</td><td>Refused on 9/14/05</td></tr>
<tr><td>MJ</td><td>9/13/05</td></tr>
<tr><td>MG</td><td>9/15/00</td></tr>
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Current recommendation:
Take additional measures to ensure that rights and responsibilities are discussed with individuals at annual WRPCs and ask individuals to sign the form at that time.
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<td>I.1.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>
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Current findings on previous recommendation:

Recommendation, June 2008:
Continue to ask individuals if "office hours" restrictions are in place and take steps to discontinue the practice.

Findings:
In response to this monitor's question at the Central Council meetings whether "office hour" restrictions continue, the individuals who responded indicated this was no longer a practice. This is consistent with the facility's audit findings.

Other findings:
In all of the units visited, the rights poster was on the wall in a common area and forms for addressing concerns to the Disability Rights office were available upon request.

Current recommendation:
Continue current practice.
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I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Determine business rules for data entry into the Records Management System (RMS) and make them applicable to all of the facilities if that is possible. **Findings:** This work is continuing. A statewide meeting with RMS administrators and the vendor was held in November. In addition, the facility has taken measures to improve the accuracy of the data in the hospital RMS. PSH has dedicated a staff member to make available reports using the data in the RMS system and to identify inconsistencies in data entry and notify the appropriate supervisory staff in the Hospital Police Department and Office of Special Investigations so that training/correction is provided to those staff members. A list of common errors was included in a 10/27/08 memo to the Hospital Administrator. A 9/24/08 memo to all HPD Sergeants clearly articulates the expectation that they are to review all RMS reports for accuracy and ensure that any corrections are made prior to the responsible officer leaving the facility. **Recommendation 2, June 2008:** On a state level, work with the vendor to develop the capacity in the RMS for producing trending and pattern reports on incidents. **Findings:** See above. At the present time, data output from the RMS is not consistently accurate. (This problem has been identified in another facility as well). Until this problem is solved, the lack of reliability in the data prevents it from being useful for tracking and trending purposes. See I.1.d.ii.

		Recommendation 3, June 2008: Until the facility has developed and trained staff on data entry rules, include a copy of the RMS incident data sheet with the investigation report that is sent to the Incident Review Committee. This will provide a second check on data accuracy. **Findings:** The facility reports that a copy of the RMS data sheet is made available to the IRC when the case is presented. **Other findings:** In several investigations reviewed, cases of assault were referred to the District Attorney. In the incident involving aggression by individual JG causing facial fractures to JS, JG was sent to the West Valley Detention Center (but was returned to PSH because of lack of room) and the case was referred to the District Attorney's office. Similarly when individual SH punched CT in the eye, CT was taken to Arrowhead Regional Medical Center and the case was referred to the DA's office. The IRC minutes in August and September document that several other incidents involving assaults against peers and against staff were referred to the District Attorney. **Current recommendation**: Continue to work with the vendor and other RMS administrators to solve the problems that result in inaccurate data output from the system.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline,	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice.

	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.	**Findings:** AD 15.13 explicitly states that facility employees, individuals, individual's family members or visitors shall not be subject to retaliation for reporting known or alleged abuse. **Other findings:** None of the investigation reports reviewed contained reference to retaliation or fear of retaliation for reporting an incident. **Current recommendation**: Continue current practice.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Recommendation 1, June 2008** Ensure that medical and nursing death reviews focus on outcomes and provision of treatment as well as documentation and treatment planning. **Findings:** The Mortality Interdisciplinary Review Committee (MIRC) review of the death of ST, completed on 3/6/08, found that the nursing death summary was incomplete. Gaps in nursing care were identified by the MIRC in its reviews of the deaths of AB, SG and JS. The recommendation for correcting one of the problems identified in the AB's death review regarding nurses' documentation of their actions during a medical emergency is poorly written and unclear.

Recommendation 2, June 2008
Continue current practice of identifying actions for improving care with timeframes and responsible parties identified. Monitor implementation.

Findings:
The MIRC minutes provided do not identify the party responsible for ensuring the implementation of the recommended corrective actions, nor is there any indication that feedback on implementation is expected.

Recommendation 3, June 2008
Determine why autopsy results are not being provided in a timely manner and take reasonable steps to address the problem if possible.

Findings:
The unavailability of autopsies and death certificates continue to impede the timely review of deaths by the Surgical/Morbidity and Mortality Committee.

Individual	Date of death	Autopsy/Death certificate status
PL	1/15/08	Autopsy pending as of 10/28/08
ST	2/23/08	Autopsy & death certificate pending
ML	6/13/08	Death certificate pending
NJ	7/29/08	Death certificate received 11/20/08
JL	8/11/08	Death certificate received 11/20/08
CM	8/20/08	Death certificate pending
DK	8/23/08	Death certificate pending
AB	8/31/08	Death certificate received 11/20/08
GJ	9/1/08	Death certificate received 11/20/08
FS	10/4/08	Death certificate pending
JS	10/15/08	Death certificate pending
JP	10/20/08	Death certificate pending

		Pending status is as of the 10/28/08 Mortality Review Committee meeting. **Recommendation 4, June 2008** Take any additional steps necessary to implement SO 205.04: Mortality Review **Findings:** The death of AB (60 years old) of an apparent heart attack was coded as an expected death. It should have been coded as an unexpected death and the protocol for review of an unexpected death should have been followed. **Recommendations:** 1. Identify the decedent by name and provide date of death in the MIRC minutes before any discussion of the circumstances of his/her death or care at the facility. 2. Ensure that the classification of deaths as expected or unexpected follows the definitions in SO 205.04 and the proper review protocol is followed. 3. Take steps to secure autopsy reports and death certificates in a timely manner. 4. Ensure that medical and nursing death reviews focus on outcomes and provision of treatment as well as documentation and treatment planning. 5. Identify in the MIRC minutes the party responsible for ensuring implementation of the recommended corrective actions and request feed-back on the measures undertaken.
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice.

	of petty theft and all other unusual incidents;	**Findings:** All staff of the Office of Special Investigations have completed investigator training. These officers investigate allegations of abuse and neglect, serious injuries and deaths. Other incidents are investigated by hospital police. **Current recommendation**: Continue current practice.
I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** None of the investigations reviewed raised any questions about the proper handling of evidence. **Current recommendation**: Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to provide an independent review of the incident investigation reports through the work of the Incident Review Committee. **Findings:** The Incident Review Committee continues to provide an independent review of Special Investigations. See findings in I.1.b.iv.3. **Current recommendation**: Provide continued IRC and supervisory attention to investigation

		reports to ensure their completeness.
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendation:** **Recommendation, June 2008:** The IRC and the Supervising Special Investigator should address the issues of timely assignment of investigations and prompt initiation of interviews. **Findings:** Most of the investigations reviewed were received by the Office of the Special Investigator in a timely fashion following a preliminary review by the hospital police in many instances, and interviews were conducted shortly after notification. See below for examples. In two reports reviewed, the initial interviews occurred weeks after the OSI was notified. The first interviews in the investigation of the allegation of verbal abuse received in the OSI on 7/25/08 were not conducted until 8/21/08. In the investigation of the allegation of physical abuse that reached the OSI on 7/30/08, the first interviews were conducted on 9/11/08.

Incident type	Date reported	Reported to OSI
Battery	6/5/08	6/6/08
Physical abuse allegation	7/24/08	7/30/08
Verbal abuse allegation	7/25/08	7/25/08
Battery	7/28/08	7/28/08
Physical abuse allegation	7/28/08	7/30/08
Physical abuse allegation	8/7/08	8/12/08
Verbal abuse allegation	8/15/08	8/18/08
Sexual assault	8/24/08	8/25/08
Verbal abuse allegation	9/14/08	9/15/08

		Current recommendation: Conduct interviews in a timely manner to avoid jeopardizing the integrity of investigations.
I.1.b.iv. 2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Identify on all incident investigations completed by Special Investigators the dates on which the Office of Special Investigations was notified and the case was assigned. **Findings:** Implementation of this recommendation was evident in many of the investigation reviewed. See I.1.b.iv.1 above. **Recommendation 2, June 2008:** Continue work on identifying a method whereby an objective person monitors a sample of investigation reports using the state-approved monitoring tool. **Findings:** This work has been assigned to the Incident Review Committee. See cell below for specific examples. **Other findings:** As presented below, the completion of investigations within the 30 business day time period specified by the EP continues to be a problem. Of the 17 non-death-related investigations reviewed, 53% were not completed within the EP timeframe.

Incident type	Date incident reported	Date investigation closed
Allegation of physical abuse	3/11/08	6/5/08
Allegation of sexual assault	6/1/08	10/6/08
Battery with serious injury	6/5/08	6/10/08
Allegation of verbal abuse	6/12/08	9/17/08
Allegation of verbal abuse	6/28/08	10/8/08
Allegation of verbal abuse	7/7/08	8/21/08
Allegation of physical abuse	7/24/08	10/14/08
Allegation of verbal abuse	7/25/08	8/22/08
Battery	7/28/08	8/5/08
Allegation of physical abuse	7/28/08	9/16/08
Allegation of neglect	7/30/08	10/14/08
Allegation of physical abuse	8/7/08	8/26/08
Inappropriate relationship between staff and individual	8/13/08	9/26/08
Allegation of verbal abuse	8/15/08	10/22/08
Allegation of sexual assault	8/24/08	10/14/08
Allegation of verbal abuse	9/14/08	10/1/08
Allegation of sexual abuse	9/15/08	9/22/08

In several of the investigations listed above, the interviews and document reviews were completed in a timely manner, but weeks lapsed before the investigation report was written and approved. The Supervising Special Investigator attributed this to workload issues. See, for example, the allegation of sexual assault made by RJ on 6/21/08. All interviews were completed on 6/22/08, but the case was not closed until 10/6/08. Similarly, the interviews of all parties related to the verbal abuse allegation made by MJ on 6/12/08 were completed within one week, but the case was not closed until 9/17/08.

The findings reported above are not consistent with the facility's audit

		findings, which determined that in the period May through October, 70% of the 40 investigations reviewed were completed within 30 business days. The listing of the status of cases prepared by the OSI indicates that five May 2008 cases, one June case, 11 July cases, 11 August cases, 15 September cases and 14 cases opened between October 1-15 remained open at the time of this review. **Current recommendation**: Continue working on the timely completion of investigations and investigation reports.
I.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, June 2008:** DMH should determine if or under what circumstances the use of a chokehold is an acceptable form of restraint in the facilities and make its determination clear to the facility administrators, police officers and facility staff members. **Findings:** No information was provided to determine if action has been taken on this recommendation. **Recommendation 2, June 2008:** Encourage the IRC and the Supervising Special Investigator to review incident investigations carefully and ensure that oversights are addressed. **Findings:** The minutes of the IRC document the Committee's attention to ensuring that investigations are complete. Examples include:

		• Minutes of 9/9/08 document that an investigation was sent back for further work because the victim had not been interviewed. • The same minutes reflect that another investigation was returned for additional work because the investigation did not address the second portion of the allegation. • A third investigation was returned because conflicting information was not reconciled or clarified. • A fourth investigation also reviewed on 9/9/08 was returned because the named staff member was not interviewed. • An investigation report reviewed during the 10/14/08 meeting was returned because the investigator did not try to identify additional witnesses. The revised and complete investigation reports were reviewed at subsequent IRC meetings. **Current recommendations**: 1. IRC and investigation supervisors should continue to review incident investigation reports for completeness and ensure that deficiencies are corrected. 2. DMH should determine if or under what circumstances a chokehold is an acceptable form of restraint in the facilities and make its determination clear to the facility administrators, police officers and facility staff members.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Cease making determinations that the named staff person in incidents involving allegations of abuse and neglect is exonerated. Make determinations, based on the preponderance of the evidence, whether the allegation is or is not sustained.

		Findings: The facility has agreed that it will stop using the determination "exonerated" except when it applies to the actions of peace officers. Use of the term is required by the Memorandum of Understanding with the Hospital Police Department bargaining unit. ["Exonerated" is used when the act under question did occur but was justified, lawful and proper.] **Recommendation 2, June 2008:** Ensure that compound allegations are fully investigated. Divide them into separate incidents and investigations if necessary. **Findings:** One of the investigation reports reviewed concerned a compound allegation: Staff member KB was alleged to have neglected individual ZO and been discourteous to a Correctional Officer. The investigation made determinations on both allegations. **Other findings:** In all of the investigation reports reviewed, the actions (by staff members and individuals) were investigated; violations were identified citing SIR definitions, nursing policies and procedures, Administrative Directives and Government Codes, as appropriate. **Current recommendation:** Implement change so that investigators do not use the term "exonerated" when making determinations about cases involving alleged staff misconduct. Reserve such determinations for investigations involving peace officers.
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendation:**

		Recommendation, June 2008: Continue current practice of identifying witnesses or the absence of witnesses. Make attempts to find additional witnesses when the circumstances of the incident indicate it is reasonable to do so, for example when the incident occurred in a location where other staff and individuals were likely to be present. **Findings:** The investigator of the 9/14/08 allegation of verbal abuse specifically questioned an individual named as a witness, asking whether any other individuals were in the area and could have heard the alleged remark. **Current recommendation**: Continue practice of asking involved parties if other persons might have heard or seen an incident under investigation.
I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, June 2008:** The IRC and the Supervising Special Investigator should review the investigations carefully and ensure that the final accepted report reflects a competent and thorough investigation. **Findings:** See I.1.b.iv.3 for examples of the IRC's attention to ensuring that investigation reports are complete. **Other findings:** All of the investigation reports reviewed clearly identified the alleged victims and perpetrators, except in one instance. The investigation report of the allegation of neglect of ZO fails to identify this individual as a victim on the face sheet. This error resulted in ZO not being entered into the RMS database as a victim in this sustained case

		of neglect. See the table in I.1.d.ii. **Current recommendation:** Ensure that in compound allegations, all victims are identified and entered into the RMS.
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, June 2008:** See I.1.b.iv.3(ii). **Findings:** See finding in See I.1.b.iv.3(ii) . **Other findings:** All of the investigation reports reviewed clearly identified on the face sheet the persons interviewed. **Current recommendation:** Continue to question whether other persons may have heard or seen an incident and interview anyone who is identified as a possible witness.
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice of taping essential interviews and providing a summary in the investigation report. **Findings:** This practice continues. Investigation reports note when tapes of interviews are available.

		Other findings: All of the investigations reviewed contained a summary of the interviews conducted. The date and time of each interview was provided and a rationale when an interview was not conducted. **Current recommendation:** Continue current practice.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue current practice. **Findings:** Investigators documented the review of relevant documents in many of the investigation reports reviewed. Examples include the following: • In investigating an allegation of verbal abuse (8/15/08), the investigator reviewed the daily roster and determined that the named staff member was not on duty on the day in question. The duty roster was also reviewed in the investigation of the alleged verbal abuse of JT (7/3/08). • In the investigation of an improper relationship between a staff member and an individual who had been in care, the investigator asked the state prison to review the individual's visitors log, which confirmed that the named staff member had visited frequently. In this same investigation, the investigator also reviewed the training record of the named staff member. **Current recommendation:** Continue current practice.

I.1.b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that all investigations include information about the incident history of the named staff member(s) and the individual(s) when conducting an investigation. **Findings:** Review of the incident history of the named staff members and individuals were documented in the vast majority of the investigation reports reviewed. Of the 14 abuse/neglect reports reviewed, the incident history of the alleged victim was reviewed in 11, and the incident history of the named staff member was reviewed in 12. **Other findings:** Beyond the review of documents and interviews, several of the investigations reviewed evidenced the use of tools/methods to obtain evidence. For example: • Use of a photo to ensure the identify of a named staff member; • Photographs of injuries; and • Consultation with physicians and psychiatrists. **Current recommendation**: Include documentation of the review of the incident history of named staff members and individuals in investigation reports.
I.1.b.iv. 3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** DMH should convene a work group to address the issues related to night rounds and make recommendations to be implemented by all of the facilities.

		Findings: The facility provided no information regarding this recommendation. **Other findings:** See other findings in I.1.b.iv.3(i). **Current recommendation:** DMH should identify its expectations concerning the issue of night rounds, addressing whether they are necessary in all instances or only under certain conditions, the frequency and the methods that are appropriate for various circumstances.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Improve documentation of attempts to reconcile conflicting evidence. **Findings:** The investigation reports reviewed did not evidence a failure to reconcile conflicting evidence. **Other findings:** In two investigations reviewed there is reason to question the determination/outcome. One case is discussed fully in I.1.c. The second case involved the 8/7/08 allegation of physical abuse made by WM. The investigator concluded that "based on WM's hearing impairment, [named staff member's] slap to the hand and shove were the only way to get her attention. Additionally, there were no injuries and based on [named staff member's] admission that he did what WM is alleging, I find that his actions were justified and therefore my findings are exonerated." Problems with this determination include:

		• The lack of an injury is not determinative of whether the actions constituted abuse. • There is no justification for the statement that a slap and a shove were the only ways to get the individual's attention. The report does not address the question of whether the individual is totally deaf nor does it address other ways of getting the individual's attention that might include gestures that do not involve physical contact. • Shoving and slapping an individual are not actions by a staff member that can be considered "justified, lawful and proper" (terms used to define exonerated). This investigation report was reviewed by the IRC during the 9/9/08 meeting. The determination was not challenged, but the case was referred to the Incident Management Committee because the individual is hearing-impaired but does not use sign language. **Current recommendation**: Review closely the rationales for determinations made at the close of investigations.
I.1.b.iv. 4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports	**Current findings on previous recommendation:** **Recommendation, June 2008:** Develop a simple database to track IRC recommendations and the responses. Review outstanding recommendations at each meeting. **Findings:** The IRC minutes evidence close tracking of pending business. In addition, the committee keeps a tracking log. **Other findings:** All of the investigation reports reviewed were signed by a supervising

	consistent with generally accepted professional standards of care.	investigator. See also I.1.b.iv.3 for work done by the IRC in ensuring that investigations are complete. **Current recommendation**: Continue the work of the IRC and the supervising investigator in reviewing investigation reports to ensure their completeness and timeliness (including timeliness of interviews.)
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendation:** **Recommendation, June 2008:** The IRC and the Supervising Special Investigator should pay careful attention to the determinations made at the close of investigations to ensure they are based on a thorough examination of all relevant facts, including consideration of programmatic violations. **Findings:** In an investigation report reviewed, the determination is open to question: Several staff complained that a staff member was spending too much time talking with a single individual in the dayroom. Ten staff members were questioned and eight disconfirmed the allegation, with several professional staff describing the staff member's behavior as model behavior. The named staff member explained her actions as compassionate, attentive care. The investigator reviewed three prior counseling memos to the named staff member that addressed bringing in food and makeup for individuals (not the individual named in this case) and allowing an unscheduled smoke break. Each of these was a policy violation. The investigation determined that the named staff member had violated policy requiring relationships to be professional and for therapeutic purposes. It further determined that the staff member violated policy for giving coffee to the individual (categorized as "inexcusable neglect of duty" for failing to follow "well known and accepted procedures") and for failing to be truthful about giving

		coffee. The case made for determining the staff member gave the individual coffee from the nurses' coffee pot and not being truthful about it is clearly defensible. The case for determining that the staff member violated policy that requires all relationships be professional and for therapeutic purposes is questionable, applying the preponderance of the evidence standard. **Other findings:** In the investigations reviewed, three staff members were found to have engaged in misconduct. In all three instances, disciplinary/ corrective actions were determined to be appropriate. In two instances the actions are pending, and in the third instance the employee resigned before termination could be effected. The Incident Review Committee minutes document several instances in which programmatic issues were identified and addressed. • The 9/23/08 minutes note that the Clinical Administrator sent a directive to the Program Directors prohibiting the practice of locking individuals in their rooms. • The 9/9/08 minutes note that the Medical Director sent a memo to all Program Directors on 4/7/08 advising them to ensure that staff are aware of the change in policy that prohibits the use of a blanket, pillow or other item to cover an individual's face during a containment or restraint. • The minutes of the 8/7/08 meeting address the issue of housing a juvenile with adults, a procedure that violates the Welfare and Institutions code. This matter was brought to the attention of the Executive Director, who has requested the assistance of DMH legal counsel.

		Compliance: Substantial, based on limited information. **Current recommendation**: Continue current practice of identifying programmatic issues in IRC meeting and addressing them directly or referring them to the appropriate body.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial.
I.1.d.i	type of incident;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Until the statewide Incident Management System is operational, continue work on using other data sources to produce trending reports based on incident type. **Findings:** As documented in the cells below, PSH has used the Record Management System database to compile lists using selected variables. These lists could theoretically be used in the future to produce tracking and trending reports. This will likely be necessary since the statewide incident management system will not be operational until early summer 2009 and will contain no historical data. However, as described below and in the table in the next cell, the data output from the RMS is incomplete. This problem has been noted at other facilities as well. **Other findings:** The facility is presently not able to produce trending reports on incidents by type. It has produced a listing of elder abuse/neglect

		incidents by type for the period May 1-Ocober 31, 2009 using the RMS data. This lists 37 physical abuse cases. The SIR data for the same time period lists 77 physical abuse cases. Either 40 cases were not entered into the RMS system or retrieval of the data has serious flaws. This same problem exists in all of the lists produced by the RMS system. **Current recommendations**: 1. Identify the extent of the problem in the mismatch between the RMS data and the SIR data and take steps to correct it. 2. Convert lists into tracking and pattern reports with analysis when the lists are reliable.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Continue with plans to work with the vendor to enable the facilities to use the Records Management System to produce tracking and trending reports. **Findings:** This work continues. **Recommendation 2, June 2008:** Take measures to ensure that data entered into the Records Management System is accurate. **Findings:** Some errors identified in the RMS report of Abuse/Neglect Case Activity have reportedly been corrected by the addition of drop-down boxes in October 2008. August and September errors included listing cases 1808 and 2198 as "open" with a disposition of "arrest," listing case 1880 as "open" with a disposition of "adverse action," and listing

case 2233 as "not substantiated" with a disposition of "arrest."
See below errors that persist and were not detected.

Recommendation 3, June 2008:
Continue the practice of reviewing the incident history of staff members to the degree that the information is available and reporting this review in investigation reports.

Findings:
In the non-death-related investigation reports reviewed, review of the incident history of both the alleged victim and the named staff member was documented in the vast majority of the reports. In most of the cases, the review of the incident history of the named staff person consisted of a finding as to whether there has been a substantiated finding of abuse in the past

Other findings:
Matching names of 12 individuals and staff from a sample of the investigations reviewed against the Case Activity report produced using the RMS—a report that purports to contain the names and role of all persons involved in the incident—yielded a poor outcome suggesting that substantial problems in retrieving data from the RMS system are ongoing. As documented below, 50% of the persons in the sample did not appear on the Case Activity report. [In the table, only single initials are used for staff members.]

Incident type	Incident date	Person involved	Listed on activity report
Verbal abuse allegation	6/12/08	MJ	No
Verbal abuse allegation	6/28/08	_ D	Yes
Verbal abuse allegation	6/28/08	_ H	Yes
Verbal abuse allegation	6/28/08	_ W	Yes
Verbal abuse allegation	7/7/08	_ P	Yes

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<tr><th>Incident type</th><th>Incident date</th><th>Person involved</th><th>Listed on activity report</th></tr>
<tr><td>Neglect allegation</td><td>7/30/08</td><td>_ B</td><td>No</td></tr>
<tr><td>Neglect</td><td>7/30/08</td><td>ZO</td><td>No</td></tr>
<tr><td>Verbal abuse allegation</td><td>8/15/08</td><td>JJ</td><td>No</td></tr>
<tr><td>Verbal abuse allegation</td><td>8/15/08</td><td>_ M</td><td>No</td></tr>
<tr><td>Verbal abuse allegation</td><td>9/14/08</td><td>_ A</td><td>Yes</td></tr>
<tr><td>Verbal abuse allegation</td><td>9/14/08</td><td>MM</td><td>No</td></tr>
<tr><td>Verbal abuse allegation</td><td>9/14/08</td><td>DT</td><td>Yes</td></tr>
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Current recommendations:
1. Identify and work with the vendor to correct errors in extracting data from the Records Management System.
2. DMH should ensure that written business rules for data entry into the RMS system apply to all of the facilities.
3. Continue to review RMS records for accuracy.
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<td>I.1.d.iii</td>
<td>individuals directly and indirectly involved;</td>
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Current findings on previous recommendation:

Recommendation, June 2008:
DMH should continue work on the statewide Incident Management System.

Findings:
This work is ongoing, and the system is expected to be available in early summer 2009.

Other findings:
See I.1.d.ii.

Current recommendation:
See relevant recommendations in I.1.d.ii.
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I.1.d.iv	location of incident;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Begin producing reports on the location of incidents as soon as the technology allows. **Findings:** Using the residential unit as the sorting variable, PSH produced a listing of all elder abuse/neglect cases for the period 5/1/08-10/31/08 based on the RMS. This listing includes battery cases (individual on individual) as well as abuse/neglect allegations that meet the SIR definitions. The listing also provides the total number of these incidents for each unit, a short synopsis of the case, the disposition, and the incident and case closure dates. On the 32 locations identified, 14 locations were the site of only one incident, seven sites figured in 2-3 incidents, eight sites in 4-5 incidents and three sites in six or more incidents. As noted above, this list undercounts the number of incidents and so is not reliable. **Current recommendation:** Use the location listing of incidents as the basis for trending and pattern data after ensuring the list is complete.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, June 2008:** Begin producing reports on the time and day of the week incidents are occurring as soon as the technology permits.

		Findings: The facility is not able to produce a tracking or pattern report on the date and time of incidents. **Current recommendation**: Ensure accuracy and completeness of RMS incident listing before using the information for tracking or pattern reports.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Complete the Headquarters Reportable Briefs and focus on contributing factors. Ask the Incident Review Committee or other bodies/staff members who could be helpful for assistance. **Findings:** Review of 10 closed Headquarters Reportable Briefs revealed that the Contributing Factors portion of the Analysis section actually addressed contributing factors in three. These include the brief concerning the 4/22/08 incident in which lack of communication between two team members contributed to the incident, the brief for the 3/30/08 incident alleging physical abuse in which there was reason to believe the individual was angry over the staff member's role in a restraint, and finally in the brief addressing the 5/5/08 suicide attempt that was caused by the individual's response to command hallucinations. In the remaining seven briefs, the Analysis section was either left blank or was a recitation of the circumstances of the incident already previously described. **Current recommendations**: 1. Review Headquarters Reportable Briefs to ensure the Analysis section is complete. 2. Request investigators and staff members completing SIRs to note

		any environmental or other conditions that may have contributed to the incident. These might include understaffing, staff unfamiliar with the individuals on the unit, particularly noisy environment, bathroom facilities out of order, virtual Mall day, etc.
I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue work on the statewide Incident Management System. **Findings:** The facility does not have the capacity to produce a report on the outcome of investigations. **Current recommendation:** If the RMS will be used as the basis for the trending and pattern reports required by the Enhancement Plan, ensure retrieved data is accurate.
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff	**Current findings on previous recommendation:** **Recommendation, June 2008:** Ensure that every investigation of an allegation of abuse and neglect addresses the question of the removal of a staff member alleged to have engaged in serious misconduct. **Findings:** Ten of the 11 relevant investigation reports reviewed addressed the question of whether the staff member was reassigned. Reassignment pending the conclusion of the investigation occurred in six of the 11 cases.

	person or volunteer may pose a risk of harm to such individuals.	**Other findings:** See the table in I.1.a.iv. All of the staff members reviewed had cleared the criminal background check. **Compliance:** Substantial. **Current recommendation:** Continue current practice.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** Interviewed: 1. C. Brown, Risk Manager 2. C. Sangdahl, MD, Psychiatrist and working part-time with Standards Compliance 3. D. Whatley, Standards Compliance 4. G. Richardson, Director, Standards Compliance 5. R. DePalmer, RN, Standards Compliance Reviewed: 1. Aggregate Trigger Data 2. Special Order262: Risk Management 3. Trigger tracking data for 10 individuals Observed: 1. Level 1 trigger meeting for Program 6 2. PSSC/Enhanced Trigger Meeting
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Review the data above [refers to behavioral trigger data reported in PSH Report 4] and investigate further to determine the factors that account for the increases.

		Findings: The facility reported that it did not have a method whereby it could determine the factors that contributed to the increase in high-risk triggers. **Recommendation 2, June 2008:** Continue identifying issues for special attention and expand the work that is already being done through the initiatives and studies cited above [refers to initiatives and studies described in PSH Report 4]. **Findings:** See findings in the cells below. Full implementation of the Risk Management system will provide attention to the clinical issues that had been the focus of special initiatives and studies. **Current recommendation**: Continue with plans to expand implementation of the Risk Management system.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Assign appropriate staff to review the quality of the trigger response and determine what minimum standards should be set for high-risk trigger responses. **Findings:** With the implementation of the incident portion of the Risk Management system that includes the Level 1 Program Review Committee and the Level 2 PSSC/Enhanced Trigger Review, the response of the WRPT is reviewed by senior clinicians.

Other findings:
Review of the teams' responses (as documented on the trigger tracking sheet) and other actions taken in response to triggers reached by 10 individuals revealed that actions were taken in each case. As reported by the Risk Manager and glimpsed in the chart below, the review processes grew more focused and leaner. This table was constructed using information from the tracking form maintained by the Risk Manager who attends and keeps minutes of the Program Review Committees meetings and the now combined PSSC/Enhanced Trigger meetings together with data from the Standards Compliance database that tracks the return of trigger tracking sheets completed by WRPTs.

Individual Trigger	Trigger tracking sheet	Other actions
BP Fall w/ injury	Updated fall risk assessment	Enhanced 10/8 & 10/23 PBS Chair will consult on Behavior Guidelines
DA Suicide attempt	Meds changed WRP modified Suicide risk assessment 1:1 observation	PRC 11/4 Enhanced 11/14. Refer to PSSC. PSSC meeting 11/25-review neuropsych testing
DS Aggression to self	Psychopharmacology consult, 1:1	PRC 10/31-psychopharm consult, evaluate need for behavior guidelines PSSC 11/6-may need DCAT, update WRP Enhanced 11/14-Referred to Medical Risk Committee PRC 11/14-mechanical soft diet
EA 2:1	No response	PRC 10/16-Update WRP risk factors, open Focus 3, refer to SAFE, get psychopharm

				consult, ensure involuntary med order does not lapse Enhanced 10/23-in agreement with PRC.
		ED 2:1	No response	Enhanced 10/8-q 15 checks PRC 10/16- off 2:1, forensic consult completed, working on behavior guidelines PSSC 11/18-transferred to new unit
		JH Suicide attempt	Meds changed Suicide risk assessment completed	Enhanced review 10/1/08-deferred to PSSC. PSSC review 10/7.
		LF Suicide attempt	No response	Program Review Committee (PRC) 10/15 and 10/22 PSSC 10/23 and 10/30 Enhanced 10/30 Now attending SAFE
		MS Aggression to self	No response	PRC 11/15-med change, new Mall group. Enhanced 11/13-update WRP, continue DBT, individual therapy
		VC 2:1	Clinical Management Committee for review	PRC 10/23-transferred to new unit. Enhanced 11/14-refer to PSSC. PSSC 12/2-PBS plan modified, team engaged. Individual doing well.
		WM 4 or + agg acts to self	No response	PSSC 9/9-PBS assessment, modify behavior guidelines PRC 9/11-beh. guidelines in

		in 30 days | | place. Enhanced 9/17-Suggest Behavioral Change Agent. The finding that 30% of the sampled trigger action sheets were not completed is not inconsistent with the facility's data showing that on average in the period between May and October, 48% were completed in a timely fashion. **Other findings:** Specific interventions commensurate with the level of risk are the central focus of the Risk Management system described in Special Order 262. The facility began implementation in late September 2008. **Current recommendation**: Continue implementation of the Risk Management Special Order in a manner that complies with the order while best meeting the needs of the individuals and using efficiently the time and talents of the staff members involved.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Continue providing training to leadership staff in using the Plato system for tracking triggers. **Findings:** The facility reported that it has provided Plato training to an increased number of staff. Six training sessions were held between June and September. **Recommendation 2, June 2008:** Continue with plans to give the Coordinator of Psychology Specialized Services access to the trigger response data in Plato.

		Findings: The facility reports that the PSSC Coordinator has been given access to Plato and a full-time staff member has been hired to maintain databases and coordinate communication between PSSC and Standards Compliance. **Recommendation 3, June 2008:** Take measures to bring the benefits of Dr. Behnam's work to all individuals with cardio-metabolic syndrome and those at risk for the syndrome. Use the blood glucose data matched with the list of persons with the syndrome or at risk for it or matched with any other data that is helpful to identify individuals in need of attention. **Findings:** The facility reports that Dr. Behnam's work continues. Results for those individuals under Dr. Behnam's treatment for metabolic syndrome show greater weight loss than for those not similarly treated. **Other findings:** The aggregate trigger data shows that two triggers related to aggression continue to remain high: individuals with two or more aggressive acts in seven consecutive days and individuals with four or more acts in 30 consecutive days. In each case there has been no decline since June 2008. The October frequency for two or more acts is equal to or exceeds the frequency for any month back to June 2007, when the data begins. The October frequency for four or more acts was exceeded only by July and September 2008. **Current recommendation**: Continue to provide expert clinical attention to individuals at high risk for aggression and to their victims.

I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Continue and expand the initiatives that target high-risk individuals. **Findings:** See I.2.a.ii for examples of work that has been done in this area. **Recommendation 2, June 2008:** Ensure that in dealing with persons involved in aggressive incidents resulting in serious injury, equal attention is paid to identifying and providing psychological services as well as physical services to individuals who are victims. **Findings:** There is no evidence presented to indicate that the level of clinical attention provided to aggressive individuals is also provided to their victims. The need for counseling and support for victims was brought up by individuals during the Central Council meetings when individuals shared stories of being hurt at the facility by other individuals. **Current recommendation**: Ensure that in dealing with persons involved in aggressive incidents resulting in serious injury, equal attention is paid to identifying and providing psychological services as well as physical services to individuals who are victims.

I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** The Risk Manager should continue to track recommendations from the Suicide/Homicide Risk Report. The Quality Improvement Team should take measures to ensure timely implementation or provide a rationale why the recommendation should not be implemented. **Findings:** The implementation of the Risk Management Special Order will ensure attention to those individuals who present as a homicide or suicide risk. **Recommendation 2, June 2008:** Continue plans to train more leadership staff on the use of Plato. **Findings:** See I.2.a.iii. **Other findings:** The work of identifying systemic trends and patterns beyond identifying individuals who repeatedly trigger has not yet begun. **Current recommendation:** As the information system capacity develops, identify patterns and trends in trigger data.
I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that WRPs respond when presented with material indicating an individual has triggered multiple times.

		Findings: Implementation of the Risk Management system will address this issue. **Recommendation 2, June 2008:** Consider recommending a hierarchy of interventions that must be implemented for individuals who trigger multiple times. **Findings:** This recommendation is being implemented with the adoption of the Risk Management Special Order. **Current recommendation**: Continue implementing the Risk Management Special Order.
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to gather data on response rates, timeliness and implementation of the actions cited. Present this information in leadership meetings that include the Program Directors. **Findings:** Information about WRPT responses to triggers and the status of implementation of promised responses is presented during the Program Review Committee meetings. **Other findings:** Approximately 15 individuals were reviewed during the Program Review Committee meeting (Program 6) observed. Unit Supervisors attended and were able to provide a picture of the individual's typical response to daily living challenges. Senior clinicians in psychiatry and psychology participated. Of particular note, several women were identified as having a history of sexual victimization, and the psychiatrist chairing

		the meeting noted that this should be listed as a risk factor related to containment. The need for drug levels, modifications in behavior guidelines, completing Axis III, resolving NOS diagnoses and contacting family members for a medication history were among the other interventions recommended. The Risk Manager kept meeting minutes, and follow-up reports on the status of the recommendations and the individual's progress or lack of progress will be presented at subsequent meetings. **Current recommendation**: Continue to expand implementation of the Risk Management system.
I.2.b.v	monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow-up.	**Current findings on previous recommendation:** **Recommendation, June 2008:** See I.2.b.ii [in PSH Report 4 dated June 2008]. **Findings:** The feedback presented at the close of the combined PSSC/Enhanced Trigger meeting suggested that the participants were generally comfortable and pleased with the format and its content. Comments included: • It was supportive rather than just criticism. • Triggers used to have no meaning. • Input from a variety of disciplines is useful. • Saves time and effort because it gets everyone on the same page. • Needs to be a forum where teams can come and ask for help. • May need to allow the designees of the Chiefs of Psychology and Psychiatry to attend on occasion, since meetings demand so much of their time.

		During the course of the meeting, when a plan of action was agreed upon, a staff member was advised that he/she should report back on whether the recommended intervention had been implemented and how the individual was doing. During the discussion of issues related to several individuals, staff members brought up challenges that the individual would face in the not-too-distant future. Interventions were agreed upon that would help the individual meet those challenges as well as the problem/trigger that brought the individual to the attention of the participants in the first place. **Current recommendation**: Continue to implement the Risk Management system in a manner that complies with the Special Order and meets the needs of the individuals by making best use of the talents and time of the clinicians who treat and/or supervise those who treat them.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue to develop initiatives and refine current procedures with the goal of managing risk through close attention to triggers on an individual and system level. **Findings:** As the facility moves forward in implementing a Wellness and Recovery treatment model, incident management system and risk management system, it will be meeting its service goals. **Compliance:** Partial. **Current recommendation**: Continue efforts to meet the requirements of the EP as resources

		become available.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. B. Ray, Health and Safety Officer 2. B. Sherer, Hospital Administrator 3. E. Haskell, Chief of Plant Operations III 4. Conversed with individuals and staff on units toured Reviewed: 1. Clinical records of seven individuals with the problem of incontinence 2. Clinical records of seven individuals named in sexual contact incidents 3. Environment of Care grid 4. Data on work orders related to temperature on the units 5. Nursing training materials on care of persons with the problem of incontinence Toured: Five residential units: 30, 34, 71, 73 and 74
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Work to ensure the timely and accurate completion of unit monthly environmental inspection reports. **Findings:** The facility reports that effective September 1, 2008, the Unit Supervisors Inspection Report form was revised to include some Joint Commission language. The facility reports that as of October 30, 2008, all Unit Supervisor inspections were current. The Health and

		Safety Environmental Survey team continues to make random, unannounced spot checks. **Recommendation 2, June 2008:** Continue efforts to involve individuals in addressing the problem. **Findings:** See other findings below. **Recommendation 3, June 2008:** Engage individuals who require assistance/encouragement to care for their person and personal space with appropriate training and other measures. **Findings:** The problem of living with individuals who refuse or are unable to care for themselves and their personal space surfaced during the Central Council meetings attended. The need to identify stronger incentives for these individuals was discussed by several attendees. **Other findings:** The minutes of the Central Council reviewed by this monitor indicate that the Health and Safety Officer attends meetings and is responsive to the concerns brought forth by individuals. For example, the November Central Council meeting minutes indicate that the Health and Safety Officer, along with the Emergency Management Coordinator, announced the procedures for an upcoming earthquake emergency drill. The Health and Safety Officer also attended the October meeting and asked for feedback from the Senate on the cleanliness of the units. The feedback was reportedly mixed. The minutes of both meetings express appreciation for the information sharing that occurred. This monitor's tour of five residential units found that the common

		areas were generally clean. Individual bedrooms were stark but generally clean, with the exception of a five-bed room in Unit 34 in which the linens on one bed were particularly soiled. Individuals spoken with had personal hygiene supplies, except one individual on Unit 73. The facility has several plans and budget proposals for eliminating the remaining suicide hazards in bathrooms and bedrooms. The recent state budget crisis may require postponing one or more of the initiatives. The work of replacing exterior window grilles (hanging hazard) in the 30 and N building has been substantially completed. Final design prints for new lockers were expected soon from Prison Industries, which will build the lockers. The locking arrangement on the present lockers represents a suicide hazard. All bathrooms and showers have been equipped with suicide-resistant handrails, and work continues on replacing showerheads and valves. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement a plan to refit those air vents that are positioned in private areas in such a way that they do not present a suicide hazard. 2. Replace the lockers as soon as possible.
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Engage individuals who require assistance/encouragement to care for their person and personal space with appropriate training and other measures.

		Findings: This monitor's tour found few instances in which individuals had clothes and food on the floor. Nearly all unoccupied beds were made, although many lacked a second sheet, which staff reported was the individual's preference. The use of plastic containers to prepare noodles without regularly washing them represents a potential health hazard. Several of these containers on Unit 30 looked as though they had not been washed in some time. Several hall lights in that unit also needed to be replaced. **Recommendation 2, June 2008:** Continue efforts to involve the Councils in addressing the cleanliness problem. **Findings:** The minutes of the Central Council indicate that cleanliness has been discussed at several meetings. Individuals raised the problem of peers who cannot or will not care for themselves or their personal space. **Other findings:** The facility reports that 99% of the 255 work orders related to hot ambient temperatures were responded to the same or next day. Similarly, 100% of the 65 work orders related to cold temperatures were completed the same or next day. All units were at a comfortable temperature during this monitor's tours. **Compliance:** Substantial as related to temperature. **Current recommendations**: 1. Ensure that plastic containers individuals commonly use to prepare food are washed regularly. 2. Replace hall lighting as needed.

I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Current findings on previous recommendations:** **Recommendation 1, June 2008:** Ensure that WRPTs understand the responsibility to correct deficiencies in planning and care identified by the audit team. **Findings:** Despite the work the facility reported doing to ensure that individuals with the problem of incontinence have appropriate objectives and interventions addressing the issue in their WRPs, this monitor's findings reported below suggest that further work is needed. The facility reports that the Nurse Administrator and Health Service Specialists have provided incontinence care training for 1168 nursing service staff (86% of total nursing staff), have provided suggestions for possible objectives and interventions addressing the problem of incontinence, and are conducting monthly monitoring. **Recommendation 2, June 2008:** Monitor for corrections on a sample basis. **Findings:** The facility's monitoring of individuals with the problem of incontinence is ongoing. **Recommendation 3, June 2008:** Share with nursing staff the facility's monitoring data, pointing out the need for their advocacy in including appropriate goals and objectives in the WRP and in teaching individuals the outcomes they hope to achieve. **Findings:** The facility has provided nursing education on the care of individuals with incontinence, has provided suggestions for objectives and interventions, and continues to monitor the care provided to these

individuals and share the audit results. Still, the findings identified below suggest that further work needs to be done to ensure that incontinence is addressed in the WRPs of individuals with that problem.

Other findings:
Review of the WRPs of seven randomly selected individuals from the list of persons with that problem provided by the facility found that the WRPs of four individuals (57%) did not address the problem.

Individual	Problem identified in audit
JB	Focus 6.9 addresses incontinence. Interventions include "individual to receive counseling 30 minutes/wk. on incontinence care." No counseling notes documented.
JC	Focus 6.9 addresses incontinence. Interventions documented.
JW	No objective or interventions
NM	No objective or interventions
PB	No objective or interventions
RS	Focus 6.6 addresses incontinence. Interventions documented.
VY	No objective or interventions

These findings are not consistent with the facility's October audit findings that 77% of the 13 clinical records of individuals with incontinence reviewed had a Focus 6 open addressing the problem.

Compliance:
Partial.

Current recommendations:
1. Continue efforts to ensure that physicians and nurses address the problem of incontinence in WRPs.
2. Take measures to ensure that clinicians document

<table>
<tr><td></td><td></td><td>discussions/counseling and other interventions identified in the WRP when they occur.</td></tr>
<tr><td>I.3.d</td><td>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</td><td>Current findings on previous recommendation:

Recommendation, June 2008:
Continue to monitor compliance with expectations around the treatment provided to individuals in sexual incidents. Ensure this information reaches physicians and psychiatrists.

Findings:
Review of the response of WRPTs to seven individuals involved in sexual incidents found the following:

<table>
<tr><td>Incident date</td><td>WRPT response</td></tr>
<tr><td>8/4/08</td><td>Notes by RN and PT present. Counseled re: No Hands On policy. Psychology note 8/5/08. Not mentioned in present status at next WRPC.</td></tr>
<tr><td>8/4/08</td><td>Note written by PT.</td></tr>
<tr><td>8/19/08</td><td>Seen by psychologist. Offered 1:1, but declined.</td></tr>
<tr><td>8/19/08</td><td>Psychology note. Counseling provided. No mention at next WRPC.</td></tr>
<tr><td>9/8/08</td><td>RN and MD notes written on 9/10. Medication change. Not mentioned at next WRPC.</td></tr>
<tr><td>9/18/09</td><td>RN note present. Not mentioned in present status at next conference. Transferred to another unit.</td></tr>
<tr><td>9/19/08</td><td>Counseling provided. Male transferred off the unit. No mention at next WRPC.</td></tr>
</table>

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

		Current recommendations: 1. Ensure that proper clinical attention is paid to the alleged victim and aggressor in instances of nonconsensual sexual contact. 2. Address victimization and aggressor behavior in the WRPs of individuals involved in nonconsensual sexual incidents.
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	**Current findings on previous recommendation:** **Recommendation, June 2008:** Continue efforts to bring all Mall facilitators up-to-date on training. **Findings:** See below. **Other findings:** The data provided by the facility show general improvement/ consistency over the review period in equipping non-unit staff Mall providers with training, with the exception of Neglect and Abuse training:

Course	May 2008 % in compliance	October 2008 % in compliance
PMAB	64%	78%
CPR	77%	83%
First Aid	84%	88%
Recovery (chapter 1)	68%	77%
By Choice	86%	86%
Patients Rights	63%	71%
Neglect and Abuse	94%	88%

Compliance:
Partial.

		Current recommendation: Continue efforts to provide all non-unit staff Mall facilitators with the full training curriculum.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. The Central Council continues to make its views and concerns known through an organized system of proposed resolutions. In response, the facility regularly sends administrators to the meetings to listen to and respond to the concerns expressed. It has prioritized the concerns it will work on for 2009. 2. The Central Council has maintained its practice of expressing appreciation for changes made as well as providing consistent and ongoing advocacy for needed change. 3. The participation of individuals in hospital committees has provided additional forums in which the views of individuals are heard.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: 1. Several individuals on the units visited 2. Listened to and questioned individuals attending the Open Forums 3. C. Clark, Administrative Liaison <u>Reviewed</u>: 1. List of facility improvements in the last six months compiled by the Central Council 2. Roadmap for 2009 compiled by the Central Council Senate 3. Analysis of Individuals' Survey responses 4. Central Council meeting minutes for May, July, September and October 2008 <u>Observed</u>: Open forums for individuals on both sides of the campus
J		**Current findings on previous recommendations:**

		Recommendation 1, June 2008: Address the issue of access to records, not only with the individuals but also with the staff members handling the requests. **Findings:** The facility is revising AD 12.07 (Access to Medical Record and AD 2.12 (Correction of Personal Health Information). When completed (expected completion date is the end of January 2009), the drafts will be reviewed by the Central Council Senate where individuals will be able to provide feedback to the administration. **Recommendation 2, June 2008:** Take measures to ensure that no individuals are waiting naked to shower. **Findings:** Questioning at the Open Forums revealed that this is not a problem. This is consistent with the facility's response that its review did not find evidence of this practice and should it occur, nursing staff would intervene. **Recommendation 3, June 2008:** Continue the practice of including individuals on facility committees as appropriate. **Findings:** The facility responded that individuals serve on the Patient Benefit Fund Committee and the By Choice committee, both facility-wide committees. Staff members serve on the Senate Canteen committee, Senate Policy Advisory committee, Senate Technology Advisory Committee and the Safety Action committees in each compound. During the Open Forums, individuals spoke about their participation in the work of several of these committees.

		Recommendation 4, June 2008: Train the remaining dining room staff on Abuse and Neglect Reporting. **Findings:** The facility reported that since July 2008, approximately 95% of the staff of nutritional services has maintained current training in Reporting Abuse and Neglect. **Recommendation 5, June 2008:** As planned, share the survey data and analysis with the individuals and with staff. **Findings:** The facility reported that it planned to share the August 2008 survey data with the Central Council Senate in December 2008. Data analysis was completed in November 2008. Analysis of the survey results comparing August 2008 with February 2008 revealed that the responses to none of the questions showed a five percent or greater improvement. Improvement (but less than five percent) was evidenced in six of the 20 questions, while downturn of less than five percent was cited for eight questions. A five percent or greater downturn was cited in response to three questions: "Staff believe that I can get better," "Staff make sure rules are followed," and "Staff talk to me about changes in medications and of my concerns about my medications." Three questions reflected no change at all: "Staff treat me with dignity and respect," "Staff encourage me to be of service to others," and "I have input into hospital rules and policies." **Other findings:** The Central Council Progress report for 2008 noted the following: • The monthly Safety Action Committee meetings have resulted in improved communication with the hospital police, search team and Grounds Presence.

		• March "Choices in Recovery Symposium" was highly successful. • Negotiation of fairer price increases and improved canteen delivery services have positively impacted the quality of life of individuals. • Random searches and searches for cause are more consistent, efficient and attentive to individuals' feelings. • The environment is cleaner. The Health and Safety Coordinator and the Risk Management Specialist attend Senate meetings and attend to problems swiftly. • More individuals are working for pay and the WORK program is viewed as successful. • Mall scheduling changes (in response to individuals' concerns) have increased personal free time. • There is a more visible connection between WRPs and Mall group assignments. • There are pockets of cultural change in the facility. Program IV is leading the way. The individuals at the Open Forums voiced concerns related to: • Excessive use of shackles, particularly during medical appointments • Need to expand video court • Need for more vocational and college-level Mall groups • Need to limit the size of Mall groups—40-50 people is too large • Discontinue the virtual Mall and allow individuals to rest/read in their rooms when there are no Mall classes • Consider allowing individuals to "buy a day off" (from Mall classes) with incentive points The Roadmap for 2009 ranks the top 10 concerns of the Central Council Senate. Two relate to the ability to initiate and receive communications from outside the facility. Ranked #8: The need for an "open telephone system with fewer or no restrictions." This includes the ability to "make and pay for our own long-distance calls, access to toll-free numbers and the use of inexpensive telephone calling cards. Ranked #4: The Package Room process for inspecting, sorting and

		delivering packages "can take weeks, even months." Individuals cite that it is "often impossible to get information about what is happening with (our) property or when we might expect to see it." **Compliance:** Partial. Substantial compliance determination dependent on results of query into telephone accessibility. **Current recommendations**: 1. Review telephone access to ensure that individuals can maintain appropriate and necessary contact with people outside the facility, including family members, legal representatives and advocates. 2. Determine methods for improving the timeliness of delivering packages to individuals.