

REPORT 8

PATTON STATE HOSPITAL

June 7-11, 2010

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

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

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

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

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

RN	Registered nurse
RNA	Restorative Nursing Assistant
R/O	Rule out
RR	Readiness Ruler (substance use services assessment tool)
S&R	Seclusion and Restraint
SA	Substance abuse; suicide attempt
SAAT	Substance Abuse Assessment Team
SAMHSA	Substance Abuse and Mental Health Services Administration
SB-5	Stanford-Binet Intelligence Scales, Fifth Edition
SC	Standards Compliance
SCD	Standards Compliance Department
SGA	Second-Generation Antipsychotic
SI	Suicidal ideation
SIB	Self-injurious behavior
SLP	Speech Language Pathology/Pathologist
SNF	Skilled Nursing Facility
SO	Special Order
SOCRATES	Stages of Change Readiness and Treatment Eagerness Scale
S/P	Status post
S/R	Seclusion/restraint
SRA	Suicide Risk Assessment
SRN	Senior/Supervising Registered Nurse
SRT	Supervising Rehabilitation Therapist
SSI	Supervising Special Investigator
TB	Tuberculosis
TD	Tardive dyskinesia
TEC	Treatment Enhancement Coordinator
TMET	Therapeutic Milieu Enhancement Team
TSI	Therapeutic Strategies and Interventions
TST	Tuberculin skin test
URN	Utilization Review Nurse
VRA	Violence Risk Assessment

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

Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP, BC; Ramasamy Manikam, PhD; Elizabeth Chura, MS, RN; and Monica Jackman, OTR/L) visited Patton State Hospital (PSH) from June 7-11, 2010 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of the facility's compliance with all action steps of the EP.

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

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

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the EP, which 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 each area, the recommendations will be directed to clinical outcomes to individuals as required by specific provisions of the EP.

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

B. Methodology

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

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

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

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

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

compliance indicates that the facility has met the Monitor's threshold of acceptable progress in implementing specific requirements of the EP.

C. Statistical Reporting

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

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

D. Findings

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

1. Key Indicator Data

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. Taken as a whole, the key indicators presented by PSH at the time of this review indicate stable or improved performance in a number of domains over the previous six months. The facility should confirm the data on the numbers of diagnoses of diabetes mellitus and of individuals receiving new generation

antipsychotics, as the data have diverged from their usual relationship.

2. Monitoring, mentoring and self-evaluation

- a. PSH has maintained significant progress in self-assessment and data presentation.
- 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 utilized all available DMH standardized auditing tools for all applicable sections of the EP.
- d. 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.

3. Implementation of the EP

- a. PSH has made additional progress towards substantial compliance with the EP. The pace of this progress has accelerated significantly during the past six months. The following are the critical factors:
 - i. An effective system of psychiatric and medical oversight that the facility's Medical Director, George Christison, MD, has put in place, specifically the leadership of Dr. Kornbluh in Psychiatry and Dr. Mach in Medical Services;
 - ii. The recent recruitment of additional highly qualified psychiatric practitioners;
 - iii. The leadership and coordination of the cognitive remediation program;
 - iv. The steady and competent hand of the Department of Standards Compliance;

- v. The maintenance of an effective training and mentoring program regarding the process of Wellness and Recovery Planning. The newly created role of Program-Wide Trainers is a significant refinement to strengthen the clinical mentoring component; and
- vi. The efforts of the entire clinical and administrative staff.
- b. The facility's progress in each domain is outlined in the corresponding section of the report.
- c. The hospital has successfully implemented the processes associated with the Risk Management system established by the Special Order. With only a few exceptions, WRPTs were found to be responsive to incidents, triggers, high risk status and Risk Management committees' recommendations. WRPs referenced incidents, triggers, and high risk status, and a focus of treatment was directed at the behavior or condition. Recommendations made by the ETRC were implemented, in process, or a rationale was provided for why implementation was no longer required. In acknowledgement of the foundational role of the Program Review Committee to the effective operation of the entire Risk Management committee structure, the hospital is providing Program Directors with additional hands-on guidance and mentoring.
- d. A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. PSH has continued its progress towards this goal, including additional progress in ensuring that providers of Mall groups and individual therapy complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-revised PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs.
- e. Psychiatrists, as attending physicians, should run groups for individuals under their care. This issue should be resolved as soon as possible in all four facilities.
- f. As mentioned earlier by this monitor, all facilities should ensure that PSR Mall groups are commensurate with the cognitive levels of the individuals at the hospital. PSH has made significant additional progress in this area.
- g. 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.
- h. Those facilities that care for 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.
- i. PSH must complete the analysis that was initiated by the facility's Medical Director, George Christison, MD, of trends, patterns and contributing factors in patient-to-staff aggression. This analysis was an excellent start, but more inter-disciplinary work is needed to address additional factors. Informed by this analysis, corrective actions must be developed and implemented.
- j. At this stage, it is critical that facility leaderships, supported by the DMH, engage in an ongoing dialogue with clinical staff about their concerns regarding the relative burden of documentation requirements and, informed by that dialogue, make any

necessary adjustments to the current system of WRP/disciplinary documentation templates and self-auditing. The following principles should guide this process:

- i. Find a reasonable allocation of time between direct care and documentation of this care; and
- ii. Tailor and prioritize documentation templates and auditing requirements to evolving clinical realities.

This should be done in a way that seeks the collaboration and incorporates the contributions of clinical staff. Within this process, it is important to find ways to ensure that the clinicians can recognize the gains/improvements that have been accomplished via the EP process, some of which may not be readily apparent to the practitioners. Working within the DMH-established leadership channels, the Medical Directors should take ownership of this process and accomplish this task in a methodical, coordinated and responsible manner.

- k. The DMH should continue its successful efforts to standardize across all hospitals the Administrative Directives that impact these services.

4. Staffing

The table below shows the staffing pattern at PSH as of April 30, 2010:

Patton State Hospital Vacancy Totals as of April 30, 2010				
Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	5.00	5.00	0.00	0%
Assistant Director of Dietetics	5.00	5.00	0.00	0%
Audiologist I	1.00	1.00	0.00	0%
Chief Dentist	1.00	1.00	0.00	0%
Chief Physician & Surgeon	1.00	1.00	0.00	0%
Chief, Central Program Services	0.00	0.00	0.00	0%
Chief Psychologist	1.00	1.00	0.00	0%
Clinical Dietician/Pre-Reg. Clin Dietician	13.00	12.00	1.00	8%
Clinical Laboratory Technologist	0.00	0.00	0.00	0%
Clinical Social Worker	96.50	96.50	0.00	0%

Patton State Hospital Vacancy Totals as of April 30, 2010

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Coordinator of Nursing Services	1.00	1.00	0.00	0%
Coordinator of Volunteer Services	1.00	1.00	0.00	0%
Dental Assistant	4.00	4.00	0.00	0%
Dentist	2.00	2.00	0.00	0%
Dietetic Technician	4.00	3.50	0.50	13%
E.E.G. Technician	0.00	0.00	0.00	0%
Food Services Technician I and II	104.00	104.00	0.00	0%
Hospital Worker	0.00	0.00	0.00	0%
Health Record Technician I	8.00	8.00	0.00	0%
Health Record Techn II Spec	3.00	3.00	0.00	0%
Health Record Techn II Supv	1.00	1.00	0.00	0%
Health Record Techn III	1.00	1.00	0.00	0%
Health Services Specialist	21.00	21.00	0.00	0%
Institution Artist Facilitator	0.00	0.00	0.00	0%
Licensed Vocational Nurse	68.00	68.00	0.00	0%
Medical Technical Assistant	0.00	0.00	0.00	0%
Medical Transcriber	5.00	5.00	0.00	0%
Medical Transcriber Sup	0.00	0.00	0.00	0%
Sr Medical Transcriber	2.00	2.00	0.00	0%
Nurse Instructor	5.00	5.00	0.00	0%
Nurse Practitioner	5.00	5.00	0.00	0%
Nurse Coordinator	12.00	12.00	0.00	0%
Office Technician	31.00	28.00	3.00	10%
Pathologist	0.00	0.00	0.00	0%

Patton State Hospital Vacancy Totals as of April 30, 2010

Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Pharmacist I	15.00	15.00	0.00	0%
Pharmacist II	1.00	1.00	0.00	0%
Pharmacist Services Manager	1.00	1.00	0.00	0%
Pharmacy Technician	11.00	11.00	0.00	0%
Physician & Surgeon	23.00	22.75	0.25	1%
Podiatrist	1.00	1.00	0.00	0%
Pre-Licensed Pharmacist	0.00	0.00	0.00	0%
Pre-Licensed Psychiatric Technician	8.00	8.00	0.00	0%
Program Assistant	8.00	4.00	4.00	50%
Program Consultant (RT,PSW)	0.00	0.00	0.00	0%
Program Director	10.00	6.00	4.00	40%
Psychiatric Nursing Education Director	1.00	1.00	0.00	0%
Psychiatric Technician	684.20	684.20	0.00	0%
Psychiatric Technician Trainee	0.00	0.00	0.00	0%
Psychiatric Technician Assistant	34.00	34.00	0.00	0%
Psychiatric Technician Instructor	1.00	1.00	0.00	0%
Psychologist-HF, (Safety)	71.30	71.30	0.00	0%
Public Health Nurse II	2.00	2.00	0.00	0%
Radiological Technologist	1.00	1.00	0.00	0%
Registered Nurse	378.90	378.90	0.00	0%
Reg. Nurse Pre Registered	0.00	0.00	0.00	0%
Rehabilitation Therapist	89.50	88.25	1.25	1%
Special Investigator	4.00	4.00	0.00	0%
Special Investigator, Senior	3.00	3.00	0.00	0%

Patton State Hospital Vacancy Totals as of April 30, 2010				
Identified Clinical Positions	Budgeted Positions	Filled Positions	Vacancies	Vacancy Rate
Speech Pathologist I	1.00	1.00	0.00	0%
Sr. Psychiatrist (Spvr)	14.20	10.00	4.20	30%
Sr. Psychologist (Spvr and Spec)	23.50	23.00	0.50	2%
Sr. Psych Tech (Safety)	75.00	75.00	0.00	0%
Sr. Radiological Technologist (Specialist)	1.00	1.00	0.00	0%
Sr. Voc. Rehab. Counselor/Voc.Rehab. Counselor 2	2.00	2.00	0.00	0%
Staff Psychiatrist	93.40	93.40	0.00	0%
Supervising Psychiatric Social Worker	5.00	5.00	0.00	0%
Supervising Registered Nurse	3.00	3.00	0.00	0%
Supervising Rehabilitation Therapist	6.00	6.00	0.00	0%
Teacher-Adult Educ./Vocational Instructor	16.30	14.00	2.30	14%
Teaching Assistant	0.00	0.00	0.00	0%
Unit Supervisor	33.00	33.00	0.00	0%
Vocational Services Instructor (Landscp Gardn) (S)	0.00	0.00	0.00	0%

Key vacancies include senior psychiatrists and Program directors.

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

F. Next Steps

1. The Court Monitor's team is scheduled to reevaluate Patton State Hospital December 6-10, 2010.
2. The Court Monitor's team is scheduled to tour Napa State Hospital July 19-23, 2010 for a follow-up evaluation.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning	
<p>Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has achieved substantial compliance with all requirements of Section C.1. 2. PSH has maintained an adequate system of mentoring and training WRPTs in the process of Wellness and Recovery Planning, including establishing the role of Program-Wide Trainers to strengthen the mentoring component. This system is sufficient to meet the future needs of the facility in this area. 3. PSH has achieved substantial compliance with most of the requirements of Section C.2. In this regard, the facility has made significant progress in the following areas: <ul style="list-style-type: none"> • Assessment of individuals with cognitive impairments; • Provision of cognitive remediation interventions to meet the needs of these individuals (for example, 13 new cognitive remediation groups were added during this review period); • Addressing the needs of individuals with seizure disorders; and • Addressing the needs of individuals with substance use disorders. 4. The facility has recruited a highly qualified psychiatrist to direct its substance use services. 5. There has been a significant increase in the Mall group scheduled hours and attended hours in the 11-20 hour category. 6. Most disciplines now are meeting or exceeding their scheduled Mall group facilitation hours. 7. Mall group cancellation has been reduced significantly. 8. There has been significant improvement in the organization and operation of supplemental activities with increases in the number of hours and activities offered, and motivational strategies to improve participation.

Section C: Integrated Therapeutic and Rehabilitation Services Planning

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:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Gari-Lyn Richardson, Director, Standards Compliance 2. George Christison, MD, Acting Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH Clinical Chart Auditing Form summary data (November 2009-April 2010) 2. PSH WRP Observation Monitoring summary data (November 2009-April 2010) 3. PSH WRPT Facilitator Observation Monitoring Form summary data (November 2009-April 2010) 4. PSH data regarding staffing ratios on admissions and long-term units (November 2009-April 2010) <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 74) for quarterly review of TMH 2. WRPC (Program I, unit U05) for quarterly review of SAN 3. WRPC (Program IV, unit 34) for monthly review of MT 4. WRPC (Program IV, unit 37) for annual review of DL 5. WRPC (Program V, unit N23) for monthly review of MLJ 6. WRPC (Program V, unit N23) for monthly review of TM 7. WRPC (Program VI, unit 71) for 14-day review of DBW 8. WRPC (Program VI, unit 71) for 14-day review of TW 9. WRPC (Program VI, unit EB10) for monthly review of CCH 10. WRPC (Program VI, unit EB02) for 14-day review of DC 11. WRPC (Program VII, unit 73) for monthly review of STJ 12. WRPC (Program VIII, unit N21) for monthly review of VA
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and	Current findings on previous recommendations:

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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.

Recommendations 1 and 2, December 2009:

- Provide a summary outline of any changes in WRP training and mentoring activities provided to the WRPTs during the reporting period.
- Continue to monitor this requirement.

Findings:

The following summarizes the facility's actions during this review period:

1. Phase II WRP training (as described in the previous report) was continued. This training was initially intended for all WRPT members. However, in an effort to ensure time efficiency for clinicians, the facility provided this training to WRPT members who were identified by supervisors or program management (or staff members in the newly created role of Program-Wide Trainer) as needing the training. The facility presented data regarding number of staff who received this training, but did not have data regarding the number of staff who required the training. The following is a summary of training data regarding number of staff competing this training:

Module	Nov	Dec	Jan	Feb	Mar	April
Present Status	45	41	56	46	32	50
Foci, Objectives and Interventions	36	35	36	49	30	56
Life Goal/Barriers to Discharge	36	32	49	47	33	52
Total	117	108	141	142	95	158

2. The facility continued computer-based Focus 6 training for nursing staff. During the previous review period, 68 RNs completed this training with the idea that they would assist with generalization of their skills to other nurses in their area. However, the facility recognized that many nurses required additional help and additional training was provided in February 2010 on a referral basis.

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		<p>To complement this training, sample Focus 6/nursing treatment plans for 20 common medical conditions, prepared in a format corresponding with EP requirements, were developed and posted on the Patton intranet in February. Drafts for an additional set of conditions were initiated.</p> <p>The facility presented data regarding number of nursing staff who completed the training but did not have information regarding the number of staff who required the training. The following is a summary of the training data:</p> <table border="1" data-bbox="1039 634 1734 711"> <thead> <tr> <th></th> <th>Nov-Jan</th> <th>Feb</th> <th>Mar</th> <th>April</th> </tr> </thead> <tbody> <tr> <td>Focus 6 Training</td> <td>0</td> <td>73</td> <td>116</td> <td>67</td> </tr> </tbody> </table> <p>3. WRPC mentoring was continued as described in the previous report. However, due to clinical demands, the number of mentors had to be decreased from 12 to nine. Mentors were discipline seniors or experienced unit clinicians (four MDs, four PhDs and one Social Worker). Two all-mentor meetings were held during the reporting period to discuss common issues and to ensure consistency of approach and standards. Starting in January 2010, 16 teams across programs were mentored. These teams were selected based on the following factors: a) presence of a newly hired psychiatrist, and/or b) did not receive mentoring in the previous reporting period, and/or c) were identified by Master Trainers as having particular need for mentoring.</p> <p>4. In addition to the above activities, the facility established a new role of Program-Wide Trainer (PWT). This was intended to provide direct coaching and feedback to WRPTs on specific WRP documents in the PWTs' assigned programs. While "Phase II" training focused on documenting components of the WRP using WaRMSS, the PWT process prioritizes clinical content. Eight trainers were selected from the disciplines of social work, rehabilitation therapy and psychology. PWTs</p>		Nov-Jan	Feb	Mar	April	Focus 6 Training	0	73	116	67
	Nov-Jan	Feb	Mar	April								
Focus 6 Training	0	73	116	67								

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		<p>reviewed documents and provided notes regarding needed corrections and then reviewed the changes made by the teams. Additionally, the PWTs acted as resources for WRPT members with questions regarding the correct completion of the WRP document. PWTs also assisted with the provision of the computer-lab based training. This facilitated consistency between what was being trained in the computer lab and what was being coached on the units.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WPRCs held each month (November 2009-April 2010):</p> <table border="1" data-bbox="982 634 1881 971"> <tr> <td data-bbox="982 634 1079 781">1.</td> <td data-bbox="1079 634 1787 781"><i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i></td> <td data-bbox="1787 634 1881 781">94%</td> </tr> <tr> <td data-bbox="982 781 1079 971">2.</td> <td data-bbox="1079 781 1787 971"><i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i></td> <td data-bbox="1787 781 1881 971">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="982 1117 1881 1312"> <thead> <tr> <th data-bbox="982 1117 1514 1198"></th> <th data-bbox="1514 1117 1703 1198">Previous period</th> <th data-bbox="1703 1117 1881 1198">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="982 1198 1881 1235">Mean compliance rate</td> <td data-bbox="1514 1198 1703 1235"></td> <td data-bbox="1703 1198 1881 1235"></td> </tr> <tr> <td data-bbox="982 1235 1514 1273">1.</td> <td data-bbox="1514 1235 1703 1273">83%</td> <td data-bbox="1703 1235 1881 1273">94%</td> </tr> <tr> <td data-bbox="982 1273 1514 1312">2.</td> <td data-bbox="1514 1273 1703 1312">62%</td> <td data-bbox="1703 1273 1881 1312">93%</td> </tr> </tbody> </table> <p>Other findings: The monitor and his experts attended 12 WPRCs. The meetings showed</p>	1.	<i>Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary and appropriate psychiatric and medical care.</i>	94%	2.	<i>Treatment, rehabilitation and enrichment services are goal-directed, individualized and informed by a thorough knowledge of the individual's psychiatric, medical and psychosocial history and previous response to such services.</i>	93%		Previous period	Current period	Mean compliance rate			1.	83%	94%	2.	62%	93%
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		<p>further progress in the overall process of the team meetings, which was sufficient to meet substantial compliance with this requirement. However, the facility should correct the deficiencies listed in C.2.e and C.2.f.iii to ensure that the individuals' needs are adequately met.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide an update of WRP training and mentoring activities provided to the WRPTs during the reporting period. 2. Continue to monitor this requirement. 			
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="982 1154 1883 1230"> <tr> <td data-bbox="982 1154 1079 1230">1.</td> <td data-bbox="1079 1154 1787 1230"><i>Each team is led by a clinical professional who is involved in the care of the individual.</i></td> <td data-bbox="1787 1154 1883 1230">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility also used the DMH WRPT Facilitator Observation Monitoring</p>	1.	<i>Each team is led by a clinical professional who is involved in the care of the individual.</i>	100%
1.	<i>Each team is led by a clinical professional who is involved in the care of the individual.</i>	100%			

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		<p>Form to assess its compliance, based on an average sample of 78% of the required observations (two WRPC observations per team per month) during the review period:</p> <table border="1" data-bbox="982 337 1885 641"> <tr> <td>1.</td> <td><i>The team psychiatrist was present.</i></td> <td>87%</td> </tr> <tr> <td>2.</td> <td><i>The team facilitator encouraged the participation of all disciplines present.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>The team facilitator ensured that the interventions were linked to the objectives.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated maintenance of a compliance rate of at least 90% from the previous review period for items 2 and 3 and the following changes in compliance for items 1 and 4:</p> <table border="1" data-bbox="982 824 1879 1096"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>88%</td> <td>87%</td> </tr> <tr> <td>4.</td> <td>87%</td> <td>97%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>1.</td> <td>88%</td> <td>95%</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The team psychiatrist was present.</i>	87%	2.	<i>The team facilitator encouraged the participation of all disciplines present.</i>	100%	3.	<i>The team facilitator ensured the "Present Status" section in the case formulation was meaningfully updated.</i>	100%	4.	<i>The team facilitator ensured that the interventions were linked to the objectives.</i>	97%		Previous period	Current period	Mean compliance rate			1.	88%	87%	4.	87%	97%	Compliance rate in last month of period			1.	88%	95%
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C.1.c	Function in an interdisciplinary fashion.	Current findings on previous recommendation:																														

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		<p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="982 524 1881 565"> <tr> <td data-bbox="982 524 1079 565">2.</td> <td data-bbox="1079 524 1787 565"><i>Each team functions in an interdisciplinary fashion.</i></td> <td data-bbox="1787 524 1881 565">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>Each team functions in an interdisciplinary fashion.</i>	99%
2.	<i>Each team functions in an interdisciplinary fashion.</i>	99%			
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Clinical Chart Audit, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="982 1377 1881 1417"> <tr> <td data-bbox="982 1377 1079 1417">1.</td> <td data-bbox="1079 1377 1787 1417"><i>The WRPT assumes primary responsibility for the</i></td> <td data-bbox="1787 1377 1881 1417">94%</td> </tr> </table>	1.	<i>The WRPT assumes primary responsibility for the</i>	94%
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		<table border="1" data-bbox="982 190 1881 305"> <tr> <td data-bbox="982 190 1079 305"></td> <td data-bbox="1079 190 1787 305"><i>individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i></td> <td data-bbox="1787 190 1881 305"></td> </tr> </table> <p data-bbox="982 347 1881 415">Comparative data indicated improvement in compliance from 83% in the previous review period.</p> <p data-bbox="982 457 1136 526">Compliance: Substantial.</p> <p data-bbox="982 568 1451 636">Current recommendation: Continue to monitor this requirement.</p>		<i>individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i>	
	<i>individual's therapeutic and rehabilitation services, and ensures the provision of competent, necessary, and appropriate psychiatric and medical care.</i>				
C.1.e	Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.	<p data-bbox="982 683 1570 711">Current findings on previous recommendation:</p> <p data-bbox="982 753 1430 821">Recommendation, December 2009: Continue to monitor this requirement</p> <p data-bbox="982 863 1906 1040">Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="982 1083 1881 1268"> <tr> <td data-bbox="982 1083 1079 1268">3.</td> <td data-bbox="1079 1083 1787 1268"><i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitation services.</i></td> <td data-bbox="1787 1083 1881 1268">97%</td> </tr> </table> <p data-bbox="982 1310 1906 1378">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	3.	<i>Each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary revising the therapeutic and rehabilitation services.</i>	97%
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.f	<p>Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: PSH used the DMH WRP Observation Monitoring Form to assess its compliance. The mean compliance rate was 99% for the review period. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.1.g	<p>Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (November 2009-April 2010):</p>

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		<table border="1" data-bbox="984 228 1881 415"> <tr> <td data-bbox="984 228 1079 415">5.</td> <td data-bbox="1079 228 1787 415"><i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i></td> <td data-bbox="1787 228 1881 415">100%</td> </tr> </table> <p data-bbox="984 459 1894 526">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="984 570 1136 636">Compliance: Substantial.</p> <p data-bbox="984 680 1451 747">Current recommendation: Continue to monitor this requirement.</p>	5.	<i>The team identifies someone to be responsible for the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</i>	100%															
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C.1.h	<p data-bbox="323 792 932 1154">Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</p>	<p data-bbox="984 792 1570 821">Current findings on previous recommendation:</p> <p data-bbox="984 865 1430 894">Recommendation, December 2009: Continue efforts to increase attendance of WRPT members at WRPCs.</p> <p data-bbox="984 976 1923 1117">Findings: PSH presented core WRPT member attendance data based on an average sample of 20% of quarterly and annual WRPCs held during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="984 1157 1749 1422"> <thead> <tr> <th data-bbox="984 1157 1329 1232"></th> <th data-bbox="1329 1157 1539 1232">Previous review period</th> <th data-bbox="1539 1157 1749 1232">Current review period</th> </tr> </thead> <tbody> <tr> <td data-bbox="984 1232 1329 1271">Individual</td> <td data-bbox="1329 1232 1539 1271">85%</td> <td data-bbox="1539 1232 1749 1271">88%</td> </tr> <tr> <td data-bbox="984 1271 1329 1310">Psychiatrist</td> <td data-bbox="1329 1271 1539 1310">88%</td> <td data-bbox="1539 1271 1749 1310">87%</td> </tr> <tr> <td data-bbox="984 1310 1329 1349">Psychologist</td> <td data-bbox="1329 1310 1539 1349">77%</td> <td data-bbox="1539 1310 1749 1349">89%</td> </tr> <tr> <td data-bbox="984 1349 1329 1388">Social Worker</td> <td data-bbox="1329 1349 1539 1388">73%</td> <td data-bbox="1539 1349 1749 1388">86%</td> </tr> <tr> <td data-bbox="984 1388 1329 1422">Rehabilitation Therapist</td> <td data-bbox="1329 1388 1539 1422">70%</td> <td data-bbox="1539 1388 1749 1422">90%</td> </tr> </tbody> </table>		Previous review period	Current review period	Individual	85%	88%	Psychiatrist	88%	87%	Psychologist	77%	89%	Social Worker	73%	86%	Rehabilitation Therapist	70%	90%
	Previous review period	Current review period																		
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		<table border="1"> <tr> <td>Registered Nurse</td> <td>96%</td> <td>98%</td> </tr> <tr> <td>Psychiatric Technician</td> <td>85%</td> <td>96%</td> </tr> </table>	Registered Nurse	96%	98%	Psychiatric Technician	85%	96%		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																		
Registered Nurse	96%	98%																										
Psychiatric Technician	85%	96%																										
C.1.i	<p>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Ensure compliance with the required ratios on the admission and long-term units. • Provide comparative data from review period to review period regarding case loads on both the admission and long-term units. <p>Findings: The facility provided the following data on average case load ratios:</p> <table border="1" data-bbox="982 935 1671 1281"> <thead> <tr> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">Admission Units</td> </tr> <tr> <td>MDs</td> <td>1:16</td> <td>1:15</td> </tr> <tr> <td>PhDs</td> <td>1:17</td> <td>1:15</td> </tr> <tr> <td>SWs</td> <td>1:15</td> <td>1:15</td> </tr> <tr> <td>RTs</td> <td>1:16</td> <td>1:15</td> </tr> <tr> <td>RNs</td> <td>1:6</td> <td>1:6</td> </tr> <tr> <td>PTs</td> <td>1:3</td> <td>1:3</td> </tr> </tbody> </table>				Previous review period	Current review period	Admission Units			MDs	1:16	1:15	PhDs	1:17	1:15	SWs	1:15	1:15	RTs	1:16	1:15	RNs	1:6	1:6	PTs	1:3	1:3
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C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	<p data-bbox="982 841 1570 873">Current findings on previous recommendation:</p> <p data-bbox="982 914 1430 979">Recommendation, December 2009: Same as C.1.a through C.1.f.</p> <p data-bbox="982 1024 1325 1089">Findings: Same as C.1.a through C.1.f.</p> <p data-bbox="982 1135 1136 1200">Compliance: Substantial.</p> <p data-bbox="982 1245 1310 1310">Current recommendation: Continue current practice.</p>																								

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2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)	
<p>Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Allison Pate, PhD, Senior Supervising Psychologist 2. Andrew Blaine, MD, Staff Psychiatrist 3. Barbara Emmons, LCSW 4. Beverly Monroe-Searcy, RT 5. Brian Starck-Riley, Assistant Director of Nutrition Services 6. Charles Ekokobe, US, Unit 34 7. Chris Keierleber, Senior Rehabilitation Therapist 8. Darryl Udell, PT 9. David Haimson, PhD, Chief of Psychology 10. Demetria Porter, RN 11. Denise Wright, PT 12. Dien X. Mach, MD, Chief Physician and Surgeon 13. Ernie Giron, By Choice staff 14. Floyd Jackson, RT 15. Gabe Mejia, LCSW, Social Worker 16. Gari-Lyn Richardson, Director, Standards Compliance 17. George Christison, MD, Acting Medical Director 18. Greg Siples, Director of Rehabilitation Therapy Services 19. Helga Thordarson, PhD, Senior Supervising Psychologist 20. Hope Marriott, LCSW, Assistant to Clinical Administrator 21. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist 22. Jason Rowden, PhD, Acting Senior Psychologist 23. Jonathan Meyer, MD, Staff Psychiatrist, Director of Substance Abuse Services 24. Joy Tilton, MD, Psychiatrist 25. Kelly Hunsicker, PhD, Psychologist 26. Kevin Garland, Supplemental Activities Coordinator 27. Mark Richards, PT, By Choice Assistant Coordinator 28. Mark Williams, PhD, PBS Team member

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		<p>29. Melanie Byde, PhD, Mall Director 30. Michael Gomes, Senior Rehabilitation Therapist 31. Michael Sewell, RN, Shift Lead 32. Mona Mosk, PsyD, Psychologist 33. Monica Brieitel, PT 34. Olayinka Kamson, MD, Psychiatrist 35. Rachel Strydom, LCSW, Supervising Social Worker 36. Ray Manuel, PT 37. Rebecca Kornbluh, MD, Acting Chief of Psychiatry 38. Renata Geyer, Senior Rehabilitation Therapist 39. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 40. Senen Castro, RN 41. Stan Hydingler, Senior Rehabilitation Therapist 42. Steve Berman, Ph.D., By Choice Coordinator 43. Susan Velasquez, PhD, PSSC Coordinator 44. Tai Kim, Director of Nutrition Services</p> <p><u>Reviewed:</u></p> <p>1. The charts of the following 136 individuals: AB, ADH, AG, AH, AIR, AKA, ALA, ALG, AMH, AR, BC, BLM, BR, CBA, CCH, CCK, CED, CEH, CES, CG, CH, CJS, CK, CMT, CR, CRH, CSC, CV, CWC, DCG, DDR, DE, DEA, DEB, DH, DJG, DJU, DLJ, DM, DRB, DWH, EAL, ER, ET, EWH, FGP, FJ, FLB, FS, GB, GD, GF, GH, GM, GNF, GW, HJA, IJ, JAH, JAS, JDM, JE, JG, JGC, JH, JHM, JL, JLB, JLO, JLS, JM-1, JM-2, JMP, JO, JRP, JS-1, JS-2, JSC, KA, KAM, KDE, KE, KKE, LAB, LJ, LJP, LM, LW, MB, MC, MEJ, MG, MLB, MLD, MLS, MP, MRB, MSB, MT, MVL, NAC, NB, NJG, NM, NNS, NT, OB, ODH, OV, PH, PLI, RAJ, RDW, REP, RH, RJ, RNM, RRA, SC, SD, SJT, SL, SLC, SPE, TG, TH, TM, TMM, TS, TT, VM, VPF, WGA, WHS, WM and WMM</p> <p>2. One WRP per team for the following 66 individuals: AIR, ALA, BCP, BLW, BS, CC, CDT, CG, CGG, CH, CNO, DB-1, DB-2, DLJ, DRB, DRM, EC, JAF, JAH, JAM, JD, JG, JJJ, JJM, JKH, JKO, JL, JLD, JMM, JS, JW, JWJ, KA, KC, KHM, KKE, KMO, LC, LF, LG, MA, MAD, MB,</p>
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		<p>MH, MLB, MLD, MMS, MW, PG, PLS, PS, PSC, RAR, RB, RL, RMM, RS, RTA, SH, SV, TCD, TFH, TMS, VHS, YR and ZB</p> <ol style="list-style-type: none"> 3. PSH WRP Observation Monitoring summary data (November 2009-April 2010) 4. PSH Clinical Chart Auditing Form summary data (November 2009-April 2010) 5. PSH Chart Auditing Form summary data (November 2009-April 2010) 6. Examples of Focus 1 objectives 7. Lesson Plans for the following Cognitive Remediation Groups: <ul style="list-style-type: none"> • Tone Chimes Choir • Learning 2 Learn My Treatment Plan • Self Help/Self Maintenance • Improving Social/Communication Skills • Movement and Rhythm • Recovery Inspired Skills Enhancement program (RISE) 8. Summary of number and types of cognitive remediation groups, current and previous review periods 9. Current and previous WRP with corresponding PSR Mall progress notes for the following five individuals: KKE, MVL, NB, SPE and WM 10. Harm Reduction Journal - Readiness Ruler article 11. Readiness Ruler measurement tool 12. Summary data substance abuse process and clinical outcomes 13. PSH Consumer Satisfaction Survey summary data 14. Comparison: SOCRATES and Readiness Ruler Stage of Change 15. Focus 5 Group Listing for Spring 2010 16. PSH WRP Substance Abuse Auditing Form summary data (November 2009-April 2010) 17. Data regarding medication education groups and individuals enrolled 18. Medication Education Knowledge Assessment Instructions 19. Hesse M: The Readiness Ruler as a measure of readiness to change in poly-drug use in drug abusers. <i>Harm Reduction Journal</i> 2006; 3(3): 1-5) 20. Results of a study regarding Stage of Change identification by two
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		<p>different instruments (conducted by Jonathan Meyer, MD, Staff Psychiatrist, Director Substance Abuse Services)</p> <ol style="list-style-type: none"> 21. List of individuals with high BMI in exercise groups 22. PSR Mall Lesson Plans 23. List of scheduled vs cancelled medical appointment 24. List of individuals who have a diagnosis of a disorder affecting cognitive functioning 25. List of psychosocial enrichment activities 26. List of scheduled exercise groups 27. Verification of competency for providing substance abuse groups 28. List of individuals with substance disorders 29. List of individuals assessed to need Family Therapy 30. List of individuals who met trigger threshold during this review period <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit 74) for quarterly review of TMH 2. WRPC (Program I, unit U05) for quarterly review of SAN 3. WRPC (Program IV, unit 34) for monthly review of MT 4. WRPC (Program IV, unit 37) for annual review of DL 5. WRPC (Program V, unit N23) for monthly review of MLJ 6. WRPC (Program V, unit N23) for monthly review of TM 7. WRPC (Program VI, unit 71) for 14-day review of DBW 8. WRPC (Program VI, unit 71) for 14-day review of TW 9. WRPC (Program VI, unit EB10) for monthly review of CCH 10. WRPC (Program VI, unit EBO2) for 14-day review of DC 11. WRPC (Program VII, unit 73) for monthly review of STJ 12. WRPC (Program VIII, unit N21) for monthly review of VA 13. Mall Group: Creative Art Therapy 14. Mall Group: Cognitive Remediation 15. Mall Group: WRAP 16. Mall Group: Cognitive Remediation Group (RISE) 17. Mall Group: Medication Education 18. Mall Group: Coping Skills
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		19. Mall Group: Social Skills			
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.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the WRPCs held each month during the review period (November 2009-April 2010). The following table summarizes the data:</p> <table border="1"> <tr> <td>6.</td> <td><i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: WRPC observations by this monitor and his consultants (see C.1.a), have, in general, verified the facility's data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>	97%
6.	<i>Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.</i>	97%			
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each	Please see sub-cells for compliance findings.			

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	individual, in particular:	
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP")) are completed within 24 hours of admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: PSH used the DMH WRP Chart Auditing Form to assess its compliance with the requirements in C.2.b.i to C.2.b.iii (November 2009-April 2010). Based on an average sample of 22% of the A-WRPs, the facility reported a mean compliance rate of 98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (BC, DJU, ET, KKE, LJ, NAC, NB, OV, TG and WHS) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Based on an average sample of 22% of the 7-day WRPs, the facility</p>

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		<p>reported a mean compliance rate of 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (BC, DJU, ET, KKE, LJ, NAC, NB, OV, TG and WHS) found compliance in all cases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
C.2.b.iii	<p>therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: The following is a summary of the facility's data:</p> <table border="1" data-bbox="991 1117 1650 1347"> <thead> <tr> <th>WRP Review</th> <th>Mean sample size</th> <th>Mean compliance rate</th> </tr> </thead> <tbody> <tr> <td>14-Day</td> <td>21%</td> <td>97%</td> </tr> <tr> <td>Monthly</td> <td>21%</td> <td>91%</td> </tr> <tr> <td>Quarterly</td> <td>23%</td> <td>91%</td> </tr> <tr> <td>Annual</td> <td>33%</td> <td>93%</td> </tr> </tbody> </table> <p>Comparative data indicated improvement in compliance since the previous</p>	WRP Review	Mean sample size	Mean compliance rate	14-Day	21%	97%	Monthly	21%	91%	Quarterly	23%	91%	Annual	33%	93%
WRP Review	Mean sample size	Mean compliance rate															
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		<p>review period:</p> <table border="1" data-bbox="991 264 1885 532"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>14-Day Review</td> <td>91%</td> <td>97%</td> </tr> <tr> <td>Monthly Review</td> <td>80%</td> <td>91%</td> </tr> <tr> <td>Quarterly Review</td> <td>80%</td> <td>91%</td> </tr> <tr> <td>Annual Review</td> <td>65%</td> <td>93%</td> </tr> </tbody> </table> <p>Other findings: A review of the charts of 10 individuals admitted during the review period found compliance in nine cases (BC, DJU, ET, LJ, NAC, NB, OV, TG and WHS) and partial compliance in one (KKE).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		Previous period	Current period	Mean compliance rate			14-Day Review	91%	97%	Monthly Review	80%	91%	Quarterly Review	80%	91%	Annual Review	65%	93%
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Annual Review	65%	93%																		
C.2.c	<p>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). • Address the process deficiencies outlined by this monitor regarding the care of individuals diagnosed with seizure disorders as part of EP requirements in Section F.7.a. <p>Findings: PSH assessed its compliance using the DMH WRP Clinical Chart Auditing</p>																		

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		<p>Form. The average samples ranged from 13% to 57% of the relevant population for each sub-indicator during the review period (November 2009-April 2010).</p> <table border="1" data-bbox="991 337 1885 863"> <tr> <td data-bbox="991 337 1087 526">2.</td> <td data-bbox="1087 337 1791 526"><i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i></td> <td data-bbox="1791 337 1885 526">93%</td> </tr> <tr> <td data-bbox="991 526 1087 639">2.a</td> <td data-bbox="1087 526 1791 639"><i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 526 1885 639">91%</td> </tr> <tr> <td data-bbox="991 639 1087 753">2.b</td> <td data-bbox="1087 639 1791 753"><i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 639 1885 753">93%</td> </tr> <tr> <td data-bbox="991 753 1087 863">2.c</td> <td data-bbox="1087 753 1791 863"><i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i></td> <td data-bbox="1791 753 1885 863">96%</td> </tr> </table> <p>Comparative data indicated improvement in the compliance rate for the main indicator from 62% in the previous review period:</p> <p>Other findings: This monitor reviewed the following:</p> <ol style="list-style-type: none"> 1. The charts of 10 individuals diagnosed with cognitive disorders (AIR, CEH, DRB, FLB, GH, JL, LAB, LW, TT and VPF); 2. PSH documents regarding the number of groups that offered cognitive remediation during the current and previous review periods; 3. Lesson plans of groups that offered cognitive remediation during this review period; and 4. The charts of seven individuals diagnosed with seizure disorders (AB, CBA, CH, MP, NM, NT and RJ). 	2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	93%	2.a	<i>When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.</i>	91%	2.b	<i>When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.</i>	93%	2.c	<i>When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.</i>	96%
2.	<i>Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services.</i>	93%												
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		<p>The reviews found general evidence of further significant progress in the following areas:</p> <ol style="list-style-type: none"> 1. The overall number of groups that offered cognitive remediation; 2. Consistency between the WRPs and the corresponding psychiatric progress notes regarding the documentation of diagnoses of cognitive impairments; 3. Performance of neuropsychological testing to assess the cognitive status of individuals relevant to seizure management (CH); 4. Provision of group interventions that offer cognitive remediation (in the charts of almost all the individuals reviewed); 5. Review of the present status of individuals diagnosed with cognitive impairments, including diagnoses of Dementia, Cognitive Disorder NOS and Mental Retardation; 6. Documentation of interventions to minimize the risks of treatment with old-generation anticonvulsant agents for individuals suffering from both seizure and cognitive disorders; 7. Documentation of appropriate foci, objectives and interventions that addressed the needs of individuals diagnosed with cognitive disorders (with few exceptions, e.g. DRB); 8. No evidence of unjustified regular use of high-risk medications, including anticholinergic medications and/or benzodiazepines for individuals suffering from dementing illnesses; 9. Review of the present status of individuals diagnosed with seizure disorders (with the exception of NT); and 10. Documentation of appropriate foci, objectives and interventions that addressed the needs of most individuals diagnosed with seizure disorders, including learning-based objectives and interventions that were properly aligned with these objectives. <p>The review found a few deficiencies in the charts of individuals diagnosed with cognitive impairments as follows:</p>
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		<ol style="list-style-type: none"> 1. The WRPs did not include a focus statement or objectives/ interventions to address the needs of one individual diagnosed with Dementia of the Alzheimer's type (DRB). 2. Review of the present status of a few individuals diagnosed with Mild Mental Retardation (CEH) and Borderline Intellectual Functioning (GH) did not address the individuals' functional and cognitive status relevant to these diagnoses. However, the WRPs of these individuals included appropriate objectives and interventions to meet the individuals' needs. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.d	<p>Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:</p>	<p>Compliance: Substantial.</p>
C.2.d.i	<p>be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>

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		<p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 414 1885 565"> <tr> <td data-bbox="991 414 1087 565">3.</td> <td data-bbox="1087 414 1791 565"><i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i></td> <td data-bbox="1791 414 1885 565">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The compliance data for the requirements in C.2.d.ii to C.2.d.vi are entered for each corresponding cell below. The sub-indicators are listed, as necessary.</p> <p>Other findings: This monitor reviewed one WRP per unit for the following 66 individuals: AIR, ALA, BCP, BLW, BS, CC, CDT, CG, CGG, CH, CNO, DB-1, DB-2, DLJ, DRB, DRM, EC, JAF, JAH, JAM, JD, JG, JJJ, JJM, JKH, JKO, JL, JLD, JMM, JS, JW, JWJ, KA, KC, KHM, KKE, KMO, LC, LF, LG, MA, MAD, MB, MH, MLB, MLD, MMS, MW, PG, PLS, PS, PSC, RAR, RB, RL, RMM, RS, RTA, SH, SV, TCD, TFH, TMS, VHS, YR and ZB. In general, there was evidence that PSH has maintained progress as described in this cell in the previous report. In addition, the facility has made adequate corrections to address the findings regarding modification of treatment/ rehabilitation interventions in response to the use of restrictive interventions. These improvements were sufficient to attain substantial compliance with the requirements of this cell. However, PSH must improve its practice in ensuring that information derived from the case formulation is properly utilized in the development of treatment/ rehabilitation objectives to</p>	3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	95%
3.	<i>The case formulation is derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis.</i>	95%			

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		<p>meet the assessed needs of individuals (see C.2.f.2 and C.2.f.iii).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.d.ii	<p>include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;</p>	<table border="1"> <tr> <td>4.</td> <td><i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i></td> <td>90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 74% in the previous review period.</p>	4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	90%
4.	<i>The case formulation includes a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status.</i>	90%			
C.2.d.iii	<p>consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;</p>	<table border="1"> <tr> <td>5.</td> <td><i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>The case formulation considers biomedical, psychosocial, and psychoeducational factors, as clinically appropriate.</i>	98%
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C.2.d.iv	<p>consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;</p>	<table border="1"> <tr> <td>6.</td> <td><i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	6.	<i>Consider such factors as age, gender, culture, treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions</i>	99%
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C.2.d.v	<p>support the diagnosis by diagnostic formulation, differential diagnosis and</p>	<table border="1"> <tr> <td>7.</td> <td><i>Support the diagnosis by diagnostic formulation,</i></td> <td>91%</td> </tr> </table>	7.	<i>Support the diagnosis by diagnostic formulation,</i>	91%
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	Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	<table border="1"> <tr> <td data-bbox="989 188 1087 305"></td> <td data-bbox="1087 188 1795 305"><i>differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i></td> <td data-bbox="1795 188 1894 305"></td> </tr> </table>		<i>differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists</i>		
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C.2.d.vi enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.		<table border="1"> <tr> <td data-bbox="989 451 1087 716">8.</td> <td data-bbox="1087 451 1795 716"><i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i></td> <td data-bbox="1795 451 1894 716">94%</td> </tr> </table>	8.	<i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i>	94%	
8.	<i>The case formulation enables the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.</i>	94%				
C.2.e The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);		<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Chart Auditing Form, PSH assessed its compliance based on an average sample of 25% of the quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p>				
		<table border="1"> <tr> <td data-bbox="989 1308 1087 1421">4.</td> <td data-bbox="1087 1308 1795 1421"><i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff</i></td> <td data-bbox="1795 1308 1894 1421">93%</td> </tr> </table>	4.	<i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff</i>	93%	
4.	<i>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives) and how the staff</i>	93%				

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		<p><i>will assist the individual to achieve his or her goals/objectives (interventions).</i></p> <p>Comparative data indicated improvement in compliance from 80% in the previous review period.</p> <p>Other findings: Chart reviews by this monitor (same as in C.2.d.i) verified that the facility has made further progress since the last review. However, in order to attain substantial compliance, the facility must improve the content of the focus and objective statements to ensure that individuals' needs are properly met. In too many cases, the focus statements were over-inclusive and did not guide the WRPTs in the proper development of objectives to meet the individuals' assessed needs. As a result, the objectives appeared to be selected by the teams in order to match the available interventions rather than addressing the assessed needs as described in the case formulation (see C.2.f.iii). In addition, a few recent examples of objectives (that were developed by the facility to assist the teams) were generic and used by too many teams without regard to the actual needs of the individuals (e.g. "Will define mental illness and medical illness").</p> <p>This monitor reviewed the records of 14 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.e. All records were in substantial compliance.</p> <p>This monitor also reviewed the records of 12 individuals who had IA-RTS assessments (admission and conversion) and Rehabilitation Therapy focused assessments (Occupational Therapy, Physical Therapy and Vocational Rehabilitation) during the review period to assess compliance with the requirements of C.2.e. All records were in substantial</p>	
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		<p>compliance.</p> <p>Finally, this monitor reviewed the records of 22 individuals with completed Nutrition Care assessments to assess compliance with the requirements of C.2.e. Nineteen records were in substantial compliance (AR, BLM, CES, CG, DDR, DEB, ER, ET, GF, GNF, JDM, JLB, JM, JSC, MEJ, MG, SC, TG and TS) and three records were in partial compliance (ADH, CRH and DCG).</p> <p>Compliance: Partial; improved compared to the last review.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Address and correct this monitor's finding of deficiency as described above. 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.f	<p>Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:</p>	<p>Please see sub-cells for compliance findings.</p>
C.2.f.i	<p>develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low</p>

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	<p>individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;</p>	<p>compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Chart Auditing Form, PSH assessed its compliance with the requirements of C.2.f.i through C.2.f.v based on an average sample of 25% of the quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 524 1887 784"> <tr> <td data-bbox="993 524 1087 784">5.</td> <td data-bbox="1087 524 1793 784"><i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that build on the individual's strengths and addresses the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i></td> <td data-bbox="1793 524 1887 784">93%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 73% in the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in all cases (KKE, MVL, NB, SPE, WGA and WM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that build 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.</i>	93%
5.	<i>The team has developed and prioritized reasonable and attainable goals/objectives (e.g. at the level of each individuals functioning) that build on the individual's strengths and addresses the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need.</i>	93%			
C.2.f.ii	<p>ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports,</p>	<p>Current findings on previous recommendation:</p>			

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	<p>motivation and readiness), and enrichment (e.g., quality of life activities);</p>	<p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH WRP Chart Auditing Form, PSH assessed its compliance based on an average sample of 25% of the quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 488 1885 638"> <tr> <td data-bbox="993 488 1087 638">6.</td> <td data-bbox="1087 488 1791 638"><i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i></td> <td data-bbox="1791 488 1885 638">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in all cases (KKE, MVL, NB, SPE, WGA and WM).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	98%
6.	<i>The objectives/interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities.)</i>	98%			
C.2.f.iii	<p>write the objectives in behavioral, observable, and/or measurable terms;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>			

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		<p>Findings: The facility reported a mean compliance rate of 91%, compared to 49% in the previous review period.</p> <p>Other findings: Findings by this monitor did not comport with the facility's compliance data in this area. Chart reviews found substantial compliance in three charts (NB, SPE and MVL), partial compliance in one (KKE) and noncompliance in two (WGA and WM). See C.2.e for review of current barrier to substantial compliance.</p> <p>Compliance: Partial.</p> <p>Current recommendations: Same as in C.2.e.</p>
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: The facility reported a mean compliance rate of 97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: Chart reviews found substantial compliance in five charts (KKE, MVL, NB, SPE and WM) and partial compliance in one (WGA).</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.v	<p>ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: The facility reported a mean compliance rate of 92%, compared to 75% in the previous review period.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in all cases (KKE, MVL, NB, SPE, WGA and WM). This assessment was based on compliance with this requirement as written. However, the facility must improve the content of foci and objective statements (see C.2.e and C.2.f.iii) to ensure that individuals' needs are properly met.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.f.vi	<p>implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>

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	<p>the 20 hours of active treatment per week; Number of individuals by category</p>	<p>Findings: PSH presented the following data for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 339 1892 644"> <thead> <tr> <th colspan="3">Hours of Mall Groups Scheduled</th> </tr> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean number of individuals</td> </tr> <tr> <td>0-5 hours</td> <td>65</td> <td>18</td> </tr> <tr> <td>6-10 hours</td> <td>35</td> <td>15</td> </tr> <tr> <td>11-15 hours</td> <td>131</td> <td>16</td> </tr> <tr> <td>16-20+ hours</td> <td>1,253</td> <td>1,551</td> </tr> </tbody> </table> <table border="1" data-bbox="993 756 1892 1078"> <thead> <tr> <th colspan="3">Hours of Mall Groups Attended</th> </tr> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean number of individuals</td> </tr> <tr> <td>0-5 hours</td> <td>235</td> <td>88</td> </tr> <tr> <td>6-10 hours</td> <td>221</td> <td>89</td> </tr> <tr> <td>11-15 hours</td> <td>417</td> <td>122</td> </tr> <tr> <td>16-20+ hours</td> <td>517</td> <td>1,302</td> </tr> </tbody> </table> <p>As seen in the tables above, Scheduled Mall hours and Attended Mall hours are moving in the right direction with the number of individuals scheduled and attending higher in the 11-15 and 16-20 hour categories.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals. The reviews focused on the documentation of active treatment hours listed in the most recent WRP and corresponding MAPP data regarding hours scheduled and</p>	Hours of Mall Groups Scheduled				Previous period	Current period	Mean number of individuals			0-5 hours	65	18	6-10 hours	35	15	11-15 hours	131	16	16-20+ hours	1,253	1,551	Hours of Mall Groups Attended				Previous period	Current period	Mean number of individuals			0-5 hours	235	88	6-10 hours	221	89	11-15 hours	417	122	16-20+ hours	517	1,302
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		<p>attended. The following table summarizes the monitor's findings:</p> <table border="1" data-bbox="993 264 1833 724"> <thead> <tr> <th>Individual</th> <th>WRP scheduled hours</th> <th>MAPP scheduled hours</th> <th>MAPP attended hours</th> </tr> </thead> <tbody> <tr> <td>GM</td> <td>20</td> <td>20</td> <td>13</td> </tr> <tr> <td>MB</td> <td>20</td> <td>20</td> <td>13</td> </tr> <tr> <td>SC</td> <td>20</td> <td>20</td> <td>12</td> </tr> <tr> <td>CK</td> <td>20</td> <td>20</td> <td>12</td> </tr> <tr> <td>JO</td> <td>19</td> <td>20</td> <td>12</td> </tr> <tr> <td>JS-28</td> <td>20</td> <td>20</td> <td>12</td> </tr> <tr> <td>JL</td> <td>20</td> <td>20</td> <td>12</td> </tr> <tr> <td>JH</td> <td>20</td> <td>19</td> <td>12</td> </tr> <tr> <td>GW</td> <td>20</td> <td>20</td> <td>12</td> </tr> <tr> <td>JS-98</td> <td>20</td> <td>20</td> <td>11</td> </tr> </tbody> </table> <p>The data in the table above indicate that there is strong correspondence between the MAPP schedule and the WRP schedule of the individual's Mall hours. Furthermore, for these randomly selected individuals, Mall group attendance is high in relation to their scheduled hours.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Individual	WRP scheduled hours	MAPP scheduled hours	MAPP attended hours	GM	20	20	13	MB	20	20	13	SC	20	20	12	CK	20	20	12	JO	19	20	12	JS-28	20	20	12	JL	20	20	12	JH	20	19	12	GW	20	20	12	JS-98	20	20	11
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JS-98	20	20	11																																											
C.2.f.vii	<p>maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and</p>	<p>Staff interview and documentation review found that none of the civilly committed individuals at PSH participate in off-site programming. According to the facility, individuals leaving the facility for off-site programming need to be accompanied by CDCR Correctional Officer, following the California Welfare and Institutions Code, Section 4107(a). Besides the fact that most if not all of the civilly committed individuals are potentially unsafe for themselves and/or the community when off-</p>																																												

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		<p>grounds, the facility also has faced difficulty with obtaining CDCR approval and supervision.</p> <p>This monitor reviewed six charts of civilly committed individuals (CJS, FS, GB, JL, JMP and RDW). The table below shows that diagnoses and behavioral issues of the six individuals, as documented in the individuals WRPs:</p> <table border="1" data-bbox="993 488 1896 1016"> <thead> <tr> <th>Individual</th> <th>Diagnoses</th> <th>Behavioral Issues</th> </tr> </thead> <tbody> <tr> <td>CJS</td> <td>Pedophilia, sexual sadism, substance abuse</td> <td>Aggression to others</td> </tr> <tr> <td>FS</td> <td>Paranoid schizophrenia, substance abuse, water intoxication</td> <td>Aggression to others, elopement, arson, emotional dysregulation</td> </tr> <tr> <td>GB</td> <td>Dementia, schizophrenia, antisocial personality, poly-substance abuse</td> <td>Aggression to others</td> </tr> <tr> <td>JL</td> <td>Schizoaffective, substance dependence</td> <td>Aggression to others</td> </tr> <tr> <td>JMP</td> <td>Impulse control, substance abuse</td> <td>Sexual battery, aggression to others, elopement</td> </tr> <tr> <td>RDW</td> <td>Pedophilia, schizophrenia</td> <td>Lewdness</td> </tr> </tbody> </table> <p>According to the Standards Compliance Director, there has been no change in the situation with the civilly committed individuals regarding off-site visits. According to the Executive Director, given the situation of not being able to program civilly committed individuals for off-site visits, PSH when possible tries to get individuals with the potential for off-site programming to sister facilities.</p>	Individual	Diagnoses	Behavioral Issues	CJS	Pedophilia, sexual sadism, substance abuse	Aggression to others	FS	Paranoid schizophrenia, substance abuse, water intoxication	Aggression to others, elopement, arson, emotional dysregulation	GB	Dementia, schizophrenia, antisocial personality, poly-substance abuse	Aggression to others	JL	Schizoaffective, substance dependence	Aggression to others	JMP	Impulse control, substance abuse	Sexual battery, aggression to others, elopement	RDW	Pedophilia, schizophrenia	Lewdness
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C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by	Current findings on previous recommendation:																					

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	<p>or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</p>	<p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Staff interview and documentation review found that PSH now uses the MAPP II process effectively, while continuing to correct bugs in the system. WRPTs now enroll individuals to PSR services directly through the MAPP II system. Enhancement Services email WRPTs when gaps in scheduling are noted. Enhancement Services also provides weekly notification to Program Management of individuals with less than 20 hours of Mall groups. PSH continues to provide MAPP II system training to all WRPTs.</p> <p>Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on a mean sample of 33% of the census each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 894 1885 1192"> <tr> <td data-bbox="993 894 1087 1192">1.</td> <td data-bbox="1087 894 1791 1192"><i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i></td> <td data-bbox="1791 894 1885 1192">96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 53% in the previous review period.</p> <p>The facility has the following plan to continue to enhance practice:</p>	1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i>	96%
1.	<i>Integrates and coordinates all services, supports, and treatments provided by or through each state hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.</i>	96%			

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		<ol style="list-style-type: none"> 1. Enhancement Services and Information Technology will continue with staff training on the MAPP II system. 2. Program Management will continue to inform WRPTs when gaps in scheduling are identified. 3. Enhancement Services will continue to provide feedback to WRPTs, Program Management, Administration, and Standard Compliance on a weekly basis as soon as MAPP II is programmed to provide scheduling information by unit and program. 4. Enhancement Services will also continue to provide daily feedback through the MAPP II Manage Requests to align treatment services with the individual's treatment needs, preferences, and interests in an effort to increase Mall attendance. <p>A review of the charts of 11 individuals found foci and objectives with relevant interventions, life goals used as strengths for interventions where appropriate, and assigned groups matching the individual's discharge needs and aligned with the objectives and foci in all 11 charts (AB, CED, DE, EWH, JM-1, JM-2, JRP, JS, KE, PLI and SL).</p> <p>PSR Mall service has been instrumental in assisting WRPs in capturing appropriate groups to meet the individual's needs. This was carried out by having the group objectives and group levels available to WRPTs.</p> <p>This monitor observed five Mall groups. There was high correspondence between the group participants' cognitive functioning and the Mall group objectives and levels.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Same as C.2.t.</p> <p>Findings: See C.2.t, sub-items 11.d and 11.e, for the facility's self monitoring data. The items that were previously reported in this cell were removed during revisions of the applicable forms due to redundancy with other audit items.</p> <p>Other findings: A review of the charts of six individuals found substantial compliance in four cases (MVL, NB, SPE and WGA) and partial compliance in two (KKE and WM). In addition, WRPC observations by this monitor found partial compliance with this requirement during the reviews of MJ and TM.</p> <p>This monitor reviewed the records of 17 individuals receiving direct occupational, physical, and speech therapy services for evidence that treatment objectives and/or modalities were modified as needed. All records were in substantial compliance.</p> <p>Compliance: Partial, improved compared to the last review.</p>

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		<p>Current recommendation: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>			
C.2.g.ii	<p>review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 93% of individuals placed in seclusion and/or restraints each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 857 1885 1044"> <tr> <td data-bbox="991 857 1087 1044">12.</td> <td data-bbox="1087 857 1791 1044"><i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i></td> <td data-bbox="1791 857 1885 1044">91%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 16% in the previous review period.</p> <p>Other findings: This monitor reviewed the charts of six individuals who experienced the use of seclusion and/or restraint during this review period. The following table outlines the reviews:</p>	12.	<i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i>	91%
12.	<i>Review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors)</i>	91%			

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		<table border="1" data-bbox="991 228 1879 534"> <thead> <tr> <th data-bbox="991 228 1157 305">Individual</th> <th data-bbox="1157 228 1518 305">Date of seclusion and/or restraint</th> <th data-bbox="1518 228 1879 305">Date of applicable WRP review</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 305 1157 342">ALA</td> <td data-bbox="1157 305 1518 342">5/22/10</td> <td data-bbox="1518 305 1879 342">5/24/10</td> </tr> <tr> <td data-bbox="991 342 1157 380">EAL</td> <td data-bbox="1157 342 1518 380">3/5/10</td> <td data-bbox="1518 342 1879 380">3/24/10</td> </tr> <tr> <td data-bbox="991 380 1157 417">FJ</td> <td data-bbox="1157 380 1518 417">4/26/10</td> <td data-bbox="1518 380 1879 417">5/18/10</td> </tr> <tr> <td data-bbox="991 417 1157 454">MSB</td> <td data-bbox="1157 417 1518 454">4/21/10</td> <td data-bbox="1518 417 1879 454">5/6/10</td> </tr> <tr> <td data-bbox="991 454 1157 492">TMM</td> <td data-bbox="1157 454 1518 492">3/15/10</td> <td data-bbox="1518 454 1879 492">4/13/10</td> </tr> <tr> <td data-bbox="991 492 1157 534">VM</td> <td data-bbox="1157 492 1518 534">3/3/10</td> <td data-bbox="1518 492 1879 534">4/14/10</td> </tr> </tbody> </table> <p data-bbox="991 574 1894 792">This review found evidence that the facility has maintained the progress described in this cell in the previous report. In addition, there was evidence of adequate corrections of previously mentioned deficiencies regarding the documentation of modification of ongoing treatment to decrease future risk and accuracy of information regarding the use of seclusion/ restraint during the interval.</p> <p data-bbox="991 834 1140 899">Compliance: Substantial.</p> <p data-bbox="991 946 1457 1011">Current recommendation: Continue to monitor this requirement.</p>	Individual	Date of seclusion and/or restraint	Date of applicable WRP review	ALA	5/22/10	5/24/10	EAL	3/5/10	3/24/10	FJ	4/26/10	5/18/10	MSB	4/21/10	5/6/10	TMM	3/15/10	4/13/10	VM	3/3/10	4/14/10
Individual	Date of seclusion and/or restraint	Date of applicable WRP review																					
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MSB	4/21/10	5/6/10																					
TMM	3/15/10	4/13/10																					
VM	3/3/10	4/14/10																					
C.2.g.iii	<p data-bbox="373 1060 966 1235">ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and</p>	<p data-bbox="991 1060 1577 1089">Current findings on previous recommendation:</p> <p data-bbox="991 1133 1457 1198">Recommendation, December 2009: Continue to monitor this requirement.</p> <p data-bbox="991 1242 1915 1421">Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (November 2009-April 2010):</p>																					

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		<table border="1" data-bbox="993 228 1887 378"> <tr> <td data-bbox="993 228 1087 378">7.</td> <td data-bbox="1087 228 1793 378"><i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i></td> <td data-bbox="1793 228 1887 378">98%</td> </tr> </table> <p data-bbox="993 418 1902 488">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 532 1902 748">Other findings: This monitor assessed the documentation of discharge criteria and the discussion of the individual's progress towards discharge (as documented in the Present Status section of the case formulation). The review found substantial compliance in five charts (KKE, NB, SPE, WGA and WM) and partial compliance in one (MVL).</p> <p data-bbox="993 792 1142 857">Compliance: Substantial.</p> <p data-bbox="993 901 1457 966">Current recommendation: Continue to monitor this requirement.</p>	7.	<i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>	98%
7.	<i>The review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status.</i>	98%			
C.2.g.iv	base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.	<p data-bbox="993 1015 1577 1047">Current findings on previous recommendation:</p> <p data-bbox="993 1091 1854 1230">Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p data-bbox="993 1274 1913 1414">Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 20% of the quarterly and annual WRPCs held each month during the review period (November 2009-April</p>			

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		<p>2010):</p> <table border="1"> <tr> <td>8.</td> <td><i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i></td> <td>93%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: This monitor's chart reviews found substantial compliance in three charts (NB, SPE and WGA) and partial compliance in three (KKE, MVL and WM).</p> <p>Compliance: Partial, improved compared to the last review.</p> <p>Current recommendation: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>	8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	93%
8.	<i>Progress reviews and revision recommendations are based on data collected as specified in the therapeutic and rehabilitation service plan.</i>	93%			
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports 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: Substantial.			
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life	Current findings on previous recommendations:			

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	<p>functions;</p>	<p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • WRPTs should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. • Continue to offer groups based on the needs of the individuals in the facility. <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 22% of quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 636 1892 748"> <tr> <td data-bbox="991 636 1087 748">2.</td> <td data-bbox="1087 636 1795 748"><i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i></td> <td data-bbox="1795 636 1892 748">97%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 65% in the previous review period.</p> <p>A review of the records of 12 individuals found that the individual's needs were appropriately addressed through the foci, objectives, and PSR interventions in 11 of the WRPs in the charts (AB, CED, DE, EWH, JM-1, JM-2, JRP, JS, KE, PLI and SL). Deficiencies, including the absence of an appropriate Mall group and poor correspondence between foci, objectives and interventions were noted in the remaining WRP (DPP).</p> <p>Other findings: This monitor reviewed the records of 14 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct therapy treatment) to assess compliance with the requirements of C.2.i.i. All records were in substantial compliance.</p>	2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	97%
2.	<i>Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions</i>	97%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Ensure that the learning outcomes are stated in measurable terms. • Ensure that each objective is directly linked to a relevant focus of hospitalization and discharge criteria. <p>Findings: Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 33% of all quarterly and annual WRPCs each month of the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 748 1890 824"> <tr> <td>1.b</td> <td><i>The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP</i></td> <td>96%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 53% in the previous review period.</p> <p>A review of the records of seven individuals found that all seven of the WRPs in the charts contained objectives written in a measurable/ observable manner and that the objectives were directly linked to a relevant focus of hospitalization (CCK, GM, HJA, IJ, JS, MLD and SLC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.b	<i>The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP</i>	96%
1.b	<i>The reviewed course outline's content is aligned with the corresponding objectives in the individual's WRP</i>	96%			
C.2.i.iii	Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Ensure that all therapies and rehabilitation services provided in the Malls</p>			

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		<p>are aligned with the objectives identified in the individual's WRP.</p> <p>Findings: Please see C.2.f.viii.</p> <p>Current recommendations: See C.2.f.viii.</p>			
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • 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. • Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services. <p>Findings: Using the DMH WRP Mall Alignment Monitoring Form, PSH assessed its compliance based on an average sample of 13% of Mall group facilitators each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1042 1892 1118"> <tr> <td data-bbox="991 1042 1087 1118">15.</td> <td data-bbox="1087 1042 1793 1118"><i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i></td> <td data-bbox="1793 1042 1892 1118">97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of WRPs of seven individuals found that all seven WRPs specified the strengths of the individual in all active interventions reviewed (CCK, GM, HJA, IJ, JS, MLD and SLC).</p>	15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	97%
15.	<i>The group facilitator utilizes the individual's strengths, preferences, and interests.</i>	97%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.i.v	<p>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Alignment Monitoring Form, PSH assessed its compliance based on observation of an average random sample of 33 WRPs each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 672 1890 786"> <tr> <td>3.</td> <td><i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of WRPs of seven individuals found that the individual's vulnerabilities were documented in the case formulation section in all seven WRPs and where appropriate the vulnerabilities were updated in the subsequent WRPs (CCK, GM, HJA, IJ, JS, MLD and SLC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	98%
3.	<i>Focuses on the individual's vulnerabilities to mental illness, substance abuse and readmission due to relapse, where appropriate.</i>	98%			
C.2.i.vi	<p>is provided in a manner consistent with each individual's cognitive strengths and limitations;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>			

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		<p>Findings: Using the DMH WRP Mall Observation Monitoring Form, PSH assessed its compliance based on an average sample of 13% of the Mall group facilitators each month during the review period (November 2009-April 2010). The following table summarizes the data:</p> <table border="1" data-bbox="993 414 1890 490"> <tr> <td data-bbox="993 414 1087 490">16.</td> <td data-bbox="1087 414 1795 490"><i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i></td> <td data-bbox="1795 414 1890 490">97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals found that cognitive screening had been conducted in all seven cases as part of the Integrated Assessment: Psychology Section or Focused Psychological Assessment (ALA, CV, DJG, GB, JG, JGC and KA).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	97%
16.	<i>Material is presented in a manner consistent with each individual's cognitive strengths and limitations.</i>	97%			
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Ensure that WRPTs receive timely progress notes on individuals' participation in their psychosocial rehabilitation services.</p> <p>Findings: PSH audited 20% of the individuals in each Program for the last month of the review period. The table below showing the number of Progress Notes due for 20% of the individuals in each 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:</p>			

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	P1	P3	P4	P5	P6	P7	P8	Mean
N	842	666	581	606	873	523	657	678
n	842	649	552	576	857	523	620	660
%C	100	97	95	95	98	100	94	97

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

Program	Previous Period	Current Period
P1	34%	100%
P3	24%	97%
P4	26%	95%
P5	30%	95%
P6	17%	98%
P7	9%	100%
P8	13%	97%

This monitor observed three WRPCs (CCH, MT and SJT). The teams reviewed the notes during the conference or had already reviewed and documented the findings in the individual's WRP prior to the conference. The teams informed this monitor that they receive most Mall progress notes in a timely fashion.

A review of the charts of five individuals found that all five contained progress notes (CCH, CSC, JLO, MT and SJT).

Other findings:
 This monitor reviewed the records of 14 individuals receiving Rehabilitation Therapy Services (including Rehabilitation Therapist-facilitated PSR Mall groups and direct Occupational and Physical therapy treatment) to assess compliance with the requirements of C.2.i.vii.

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		<p>Thirteen records were in substantial compliance (AKA, ALG, DEB, GD, JLS, KAM, KDE, MC, MRB, OB, ODH, REP and TM) and one record was not in compliance (JAS).</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																
C.2.i.viii	<p>is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups • Continue current practice. <p>Findings: PSH continues to provide Mall services for five days a week (Monday through Friday) with two hours in the mornings and two hours in the afternoons. The table below showing the number of individuals in the census for the review month (N) and the number of Mall hours provided for each month of this review period is a summary of the facility's data:</p> <table border="1" data-bbox="991 971 1913 1198"> <thead> <tr> <th colspan="8">Hours of Mall Groups Provided</th> </tr> <tr> <th>2009/ 2010</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>1,573</td> <td>1,582</td> <td>1,628</td> <td>1,628</td> <td>1,591</td> <td>1,595</td> <td>1,600</td> </tr> <tr> <td>Total Hours</td> <td>8,876</td> <td>7,101</td> <td>11,043</td> <td>10,119</td> <td>10,526</td> <td>11,945</td> <td>9,935</td> </tr> </tbody> </table> <p>Current recommendation: Continue to monitor this requirement.</p>	Hours of Mall Groups Provided								2009/ 2010	Nov	Dec	Jan	Feb	Mar	Apr	Mean	N	1,573	1,582	1,628	1,628	1,591	1,595	1,600	Total Hours	8,876	7,101	11,043	10,119	10,526	11,945	9,935
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2009/ 2010	Nov	Dec	Jan	Feb	Mar	Apr	Mean																											
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Total Hours	8,876	7,101	11,043	10,119	10,526	11,945	9,935																											
C.2.i.ix	<p>is provided to individuals in bed-bound status in a manner and for a period that is</p>	<p>Current findings on previous recommendations:</p>																																

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	<p>commensurate with their medical status;</p>	<p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • If the facility cares for bed-bound individuals, ensure that those individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical, health, and physical limitations. • If the facility cares for individuals who are unable to ambulate or be transferred, ensure that therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities. <p>Findings: PSH did not have any bed-bound individuals during this review period. However, the facility has plans in place to address the needs of bed-bound individuals upon admission.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																
<p>C.2.i.x</p>	<p>routinely takes place as scheduled;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Ensure that Mall groups and individual therapies are cancelled rarely, if ever. • Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. <p>Findings: PSH presented the following data regarding cancellation of Mall groups:</p> <table border="1" data-bbox="991 1263 1896 1377"> <thead> <tr> <th></th> <th>11/09</th> <th>12/09</th> <th>1/10</th> <th>2/10</th> <th>3/10</th> <th>4/10</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Groups scheduled</td> <td>8,650</td> <td>5,800</td> <td>8,864</td> <td>8,403</td> <td>8,336</td> <td>8,294</td> <td>8,058</td> </tr> </tbody> </table>		11/09	12/09	1/10	2/10	3/10	4/10	Mean	Groups scheduled	8,650	5,800	8,864	8,403	8,336	8,294	8,058
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Groups scheduled	8,650	5,800	8,864	8,403	8,336	8,294	8,058											

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	11/09	12/09	1/10	2/10	3/10	4/10	Mean
Groups cancelled	999	862	1,022	343	55	27	551
Cancellation rate	8%	14%	11%	4%	1%	1%	7%

As the table above shows, PSH's Mall cancellation stands at a mean of 7%. The table also shows that the mean Mall cancellation for the last two months of this review period was 1%. The mean Mall cancellation rate was 8% in the previous review period.

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

Average weekly hours provided by discipline		
	Previous review period	Current review period
Psychiatry ACUTE (4)	3	2
Psychiatry L-T (8)	3	2.49
Psychology ACUTE (5)	5	5
Psychology L-T (10)	9	9.25
Social Work ACUTE (5)	5	4.75
Social Work L-T (10)	9	9.38
Rehab Therapy ACUTE (7)	9.2	9.29
Rehab Therapy L-T (15)	12.2	12.66
Nursing (10)	10	10
Administration	1.17	2.50

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		<table border="1" data-bbox="991 228 1885 573"> <thead> <tr> <th>Discipline</th> <th>Hours Scheduled/Week</th> <th>Hours Provided/Week</th> <th>Percentage of Scheduled Hours Fulfilled</th> </tr> </thead> <tbody> <tr> <td>Psychiatry</td> <td>4.25</td> <td>2.25</td> <td>52.95%</td> </tr> <tr> <td>Psychology</td> <td>8.30</td> <td>7.97</td> <td>96.03%</td> </tr> <tr> <td>Social Work</td> <td>8.32</td> <td>7.89</td> <td>94.84%</td> </tr> <tr> <td>Rehab Therapy</td> <td>12.02</td> <td>11.61</td> <td>96.59%</td> </tr> <tr> <td>Nursing</td> <td>10.00</td> <td>10.00</td> <td>100.00%</td> </tr> <tr> <td>Other</td> <td>10.00</td> <td>10.00</td> <td>100.00%</td> </tr> <tr> <td>Administration</td> <td>2.60</td> <td>2.50</td> <td>96.00%</td> </tr> </tbody> </table> <p data-bbox="991 613 1919 792">As the tables above show, the number of PSR Mall hours facilitated by the different disciplines as a ratio of the hours scheduled per discipline has increased for all disciplines since the last review period. Almost all disciplines now meet their required scheduled hours, with the exception of Psychiatry.</p> <p data-bbox="991 837 1457 902">Current recommendation: Continue to monitor this requirement.</p>	Discipline	Hours Scheduled/Week	Hours Provided/Week	Percentage of Scheduled Hours Fulfilled	Psychiatry	4.25	2.25	52.95%	Psychology	8.30	7.97	96.03%	Social Work	8.32	7.89	94.84%	Rehab Therapy	12.02	11.61	96.59%	Nursing	10.00	10.00	100.00%	Other	10.00	10.00	100.00%	Administration	2.60	2.50	96.00%
Discipline	Hours Scheduled/Week	Hours Provided/Week	Percentage of Scheduled Hours Fulfilled																															
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Other	10.00	10.00	100.00%																															
Administration	2.60	2.50	96.00%																															
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	<p data-bbox="991 951 1577 979">Current findings on previous recommendation:</p> <p data-bbox="991 1024 1436 1089">Recommendation, December 2009: Continue current practice.</p> <p data-bbox="991 1135 1890 1201">Findings: The facility provided the following data regarding enrichment activities:</p> <table border="1" data-bbox="991 1240 1879 1411"> <thead> <tr> <th></th> <th>11/09</th> <th>12/09</th> <th>1/10</th> <th>2/10</th> <th>3/10</th> <th>4/10</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Hours scheduled</td> <td>1716</td> <td>1716</td> <td>2145</td> <td>1716</td> <td>1716</td> <td>1716</td> <td>1788</td> </tr> <tr> <td>Hours offered</td> <td>1716</td> <td>1716</td> <td>2145</td> <td>1716</td> <td>1716</td> <td>1716</td> <td>1788</td> </tr> </tbody> </table>		11/09	12/09	1/10	2/10	3/10	4/10	Mean	Hours scheduled	1716	1716	2145	1716	1716	1716	1788	Hours offered	1716	1716	2145	1716	1716	1716	1788								
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		<table border="1" data-bbox="991 191 1879 259"> <tr> <td>Compliance rate</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </table> <p>PSH has made significant improvements in its offerings of enrichment activities in both the hours scheduled (mean of 52 hours during the previous period) and hours offered (mean of 51 hours during the previous period), as well as in its methodology and monitoring of these activities.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Compliance rate	100%	100%	100%	100%	100%	100%	100%																
Compliance rate	100%	100%	100%	100%	100%	100%	100%																			
C.2.i.xii	is consistently reinforced by staff on the therapeutic milieu, including living units.	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the Therapeutic Milieu Observation Monitoring Form, PSH assessed its compliance based on observations of an average sample of 94% of the units in the facility. The following table summarizes the facility's data:</p> <table border="1" data-bbox="991 966 1879 1416"> <tr> <td>1.</td> <td><i>More staff are in the Milieu than in the nursing station.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Some staff in the Milieu are interacting with individuals, not simply observing them.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>There are unit recognition programs.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Unit rules are posted and reflect recovery language and principles.</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Unit bulletin boards are posted with religious and cultural activities.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Staff respect confidentiality.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Some staff are actively engaged in listening.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Staff interact with individuals in a respectful and</i></td> <td>100%</td> </tr> </table>	1.	<i>More staff are in the Milieu than in the nursing station.</i>	100%	2.	<i>Some staff in the Milieu are interacting with individuals, not simply observing them.</i>	100%	3.	<i>There are unit recognition programs.</i>	100%	4.	<i>Unit rules are posted and reflect recovery language and principles.</i>	100%	5.	<i>Unit bulletin boards are posted with religious and cultural activities.</i>	100%	6.	<i>Staff respect confidentiality.</i>	100%	7.	<i>Some staff are actively engaged in listening.</i>	100%	8.	<i>Staff interact with individuals in a respectful and</i>	100%
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		<table border="1" data-bbox="993 190 1890 305"> <tr> <td></td> <td><i>courteous manner.</i></td> <td></td> </tr> <tr> <td>9.</td> <td><i>Staff respect privacy.</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Staff react calmly in an escalating situation</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: A review of the charts of seven individuals found that all seven contained milieu interventions appropriate to the active intervention (CCK, GM, HJA, IJ, JS, MLD and SLC).</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>courteous manner.</i>		9.	<i>Staff respect privacy.</i>	100%	10.	<i>Staff react calmly in an escalating situation</i>	100%																			
	<i>courteous manner.</i>																													
9.	<i>Staff respect privacy.</i>	100%																												
10.	<i>Staff react calmly in an escalating situation</i>	100%																												
C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> Track and review participation of individuals in scheduled group exercise and recreational activities. Implement corrective action if participation is low. <p>Findings: The facility presented the following data to indicate the number of groups needed and the number of groups offered for the individuals requiring the services:</p> <table border="1" data-bbox="993 1195 1890 1422"> <thead> <tr> <th colspan="7">Exercise Groups Offered vs. Needed</th> </tr> <tr> <th>2009/2010</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> </tr> </thead> <tbody> <tr> <td>Number of groups offered</td> <td>131</td> <td>131</td> <td>126</td> <td>126</td> <td>126</td> <td>131</td> </tr> <tr> <td>Number of groups needed</td> <td>51</td> <td>53</td> <td>55</td> <td>55</td> <td>55</td> <td>55</td> </tr> </tbody> </table>	Exercise Groups Offered vs. Needed							2009/2010	Nov	Dec	Jan	Feb	Mar	Apr	Number of groups offered	131	131	126	126	126	131	Number of groups needed	51	53	55	55	55	55
Exercise Groups Offered vs. Needed																														
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		<table border="1" data-bbox="991 191 1902 232"> <tr> <td>Offered/needed</td> <td><100%</td> <td><100%</td> <td><100%</td> <td><100%</td> <td><100%</td> <td><100%</td> </tr> </table> <p data-bbox="991 272 1902 345">The facility also presented the following data to show the percentage of individuals with high BM's assigned to exercise groups:</p> <table border="1" data-bbox="991 378 1875 609"> <thead> <tr> <th>BMI Level</th> <th>Individuals in each category</th> <th>Individuals assigned to Exercise Groups</th> <th>Percentage assigned</th> </tr> </thead> <tbody> <tr> <td>25 - 30</td> <td>641</td> <td>592</td> <td>92%</td> </tr> <tr> <td>31 - 35</td> <td>335</td> <td>321</td> <td>96%</td> </tr> <tr> <td>36 - 40</td> <td>160</td> <td>149</td> <td>93%</td> </tr> <tr> <td>>40</td> <td>64</td> <td>59</td> <td>92%</td> </tr> </tbody> </table> <p data-bbox="991 649 1917 833">As the first table above indicates, PSH provided more than the necessary number of exercise groups to accommodate all individuals with a high BMI. PSH also had enrolled most individuals with high BMIs to these exercise groups. PSH should ensure that the remaining individuals are enrolled to exercise groups and/or similar energy-expending activities.</p> <p data-bbox="991 873 1812 946">The following are suggestions for further improvement during the maintenance phase:</p> <ol data-bbox="991 987 1917 1239" style="list-style-type: none"> 1. Consider providing alternate/equivalent activities if physical factors or illness are limitations to enrolling an individual in an exercise program. 2. Consider Occupational Therapy services for some individuals (including bed-bound individuals). 3. Document reasons for not enrolling individuals with high BMIs in exercise groups in the Present Status section of the individual's WRP. <p data-bbox="991 1279 1140 1352">Compliance: Substantial.</p> <p data-bbox="991 1393 1308 1421">Current recommendation:</p>	Offered/needed	<100%	<100%	<100%	<100%	<100%	<100%	BMI Level	Individuals in each category	Individuals assigned to Exercise Groups	Percentage assigned	25 - 30	641	592	92%	31 - 35	335	321	96%	36 - 40	160	149	93%	>40	64	59	92%
Offered/needed	<100%	<100%	<100%	<100%	<100%	<100%																							
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		Continue to monitor this requirement.						
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH C2k Family Therapy Auditing Form, PSH assessed its compliance based on an average sample of 100% of individuals with an assessed need for family therapy services and a signed release for family contact, and are receiving family therapy education/services:</p> <table border="1" data-bbox="991 673 1887 824"> <tr> <td data-bbox="991 673 1087 824">1.</td> <td data-bbox="1087 673 1793 824"><i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i></td> <td data-bbox="1793 673 1887 824">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH C2k Family Therapy Auditing Form, PSH also assessed its compliance based on an average sample of 13% of individuals with an assessed need for family therapy services and a signed release for family contact, and are receiving family therapy education/services:</p> <table border="1" data-bbox="991 1156 1887 1382"> <tr> <td data-bbox="991 1156 1087 1382">2.</td> <td data-bbox="1087 1156 1793 1382"><i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i></td> <td data-bbox="1793 1156 1887 1382">94%</td> </tr> </table>	1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100%	2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	94%
1.	<i>Admission: General family education is provided to the family. SW has assessed the family's ability and willingness to be involved, and has identified and documented barriers to family involvement.</i>	100%						
2.	<i>Long-Term: Efforts to involve the family, and continuing efforts and outcomes of attempts to decrease barriers to family involvement are documented in the Present Status, and Focus 11 contains an objective that prepares the individual for his or her role within their family system.</i>	94%						

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		<p>Using the DMH C2k Family Therapy Auditing Form, PSH assessed its compliance based on an average sample of 100% of individuals who are in the process of being discharged to their families:</p> <table border="1" data-bbox="991 337 1887 561"> <tr> <td data-bbox="991 337 1087 561">3.</td> <td data-bbox="1087 337 1793 561"><i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i></td> <td data-bbox="1793 337 1887 561">100%</td> </tr> </table> <p>A review of the records of five individuals with assessed need for family therapy services (CWC, DEA, FGP, LJP and MLS) found documentation in the Present Status section of all five WRPs indicating the receipt of family therapy services and/or contact between SW staff and the individual's family members. SW is in touch with and has mailed information to the families of CWC, DEA and MLS. SW has met with FGP's family and the family has not taken up the offer of family therapy/education. LJP did not agree to renew consent as his father passed away last year, his mother is old, and his other family members (brothers and sisters) live out of state.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i>	100%
3.	<i>Discharge: There is documentation in the Medical Record that family consultation and counseling was provided, the family was provided the individual's Social Work Recommended Continuing Care Plan, and information was provided to the family on community resources.</i>	100%			
C.2.1	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Increase sample size to 20% for audits regarding items 1-5.</p>			

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	<p>nurses ["LVNs" and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.</p>	<p>Findings: PSH increased the sample size to 21% for this review period.</p> <p>Recommendations 2 and 3, December 2009:</p> <ul style="list-style-type: none"> Continue to implement strategies as noted [in this cell in the previous report] to increase compliance with this requirement. Continue to monitor this requirement. <p>Findings: Using the DMH Integration of Medical Conditions in WRP Audit, PSH assessed its compliance based on a 21% mean sample of individuals with at least one Axis III diagnosis who had a WRP due during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="993 711 1892 1084"> <tr> <td>1.</td> <td><i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i></td> <td>94%</td> </tr> <tr> <td>2.</td> <td><i>The WRP includes each medical condition or diagnoses listed on Axis III.</i></td> <td>91%</td> </tr> <tr> <td>3.</td> <td><i>There is an appropriate focus statement for each medical condition or diagnosis.</i></td> <td>91%</td> </tr> <tr> <td>4.</td> <td><i>There is an appropriate objective for each medical condition or diagnosis.</i></td> <td>91%</td> </tr> <tr> <td>5.</td> <td><i>There are appropriate interventions for each objective.</i></td> <td>90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="993 1235 1892 1424"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>76%</td> <td>94%</td> </tr> <tr> <td>2.</td> <td>71%</td> <td>91%</td> </tr> </tbody> </table>	1.	<i>All medical conditions listed on Axis III are included on the Medical Conditions Form.</i>	94%	2.	<i>The WRP includes each medical condition or diagnoses listed on Axis III.</i>	91%	3.	<i>There is an appropriate focus statement for each medical condition or diagnosis.</i>	91%	4.	<i>There is an appropriate objective for each medical condition or diagnosis.</i>	91%	5.	<i>There are appropriate interventions for each objective.</i>	90%		Previous period	Current period	Mean compliance rate			1.	76%	94%	2.	71%	91%
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		<table border="1"> <tr> <td>3.</td> <td>47%</td> <td>91%</td> </tr> <tr> <td>4.</td> <td>64%</td> <td>91%</td> </tr> <tr> <td>5.</td> <td>49%</td> <td>90%</td> </tr> </table>	3.	47%	91%	4.	64%	91%	5.	49%	90%	
3.	47%	91%										
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<p>A review of the WRPs of 40 individuals (AAA, AB, AJB, AL, AS, CHC, CP, CW, DL, EMM, FGC, FL, HAT, JA, JAD, JAG, JAP, JG, JL, KA, LDF, LHH, LJ, LLP, MAA, MDM, MVV, NDR, NJK, PAR, PCJ, PDU, PMC, SCH, SF, SMM, SPE, SRT, STS and TLD) found that PSH has made continual significant improvements regarding adequate and appropriate nursing objectives and interventions for Focus 6 with the exception of the area of infection control, which is addressed in Section F.8. The majority of the WRPs reviewed for Focus 6 included appropriate objectives and interventions, which comports with PSH's data.</p> <p>PSH also assessed its compliance using the DMH Integration of Medical Conditions in WRP audit, based on an average sample of 100% of individuals scheduled for but refusing to receive medical procedure(s), including laboratory tests, during the review months (49 individuals):</p>		<table border="1"> <tr> <td data-bbox="978 893 1087 1015">6.</td> <td data-bbox="1087 893 1795 1015"><i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals of medical procedures.</i></td> <td data-bbox="1795 893 1917 1015">98%</td> </tr> </table>	6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals of medical procedures.</i>	98%							
6.	<i>Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals of medical procedures.</i>	98%										
<p>Comparative data indicated improvement in compliance from 30% in the previous review period.</p> <p>A review of PSH's data regarding the number of individuals who refused their dental appointments each month during the review period (see F.9.d) and the number of other refusals of appointments/procedures as reported by the Medical Director (up to 500 per month) indicated that there was a significant discrepancy between the actual number of refusals and the data sample (49 individuals) reflected in the table above. Please see F.9.e for a description of this system and chart review findings.</p>												

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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to develop and implement a system addressing this requirement that includes a system to track this specific population. 2. Continue to monitor this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	<p>The requirements of Section C.2.m are not applicable because PSH does not serve children and adolescents.</p>
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The facility reported the following substance abuse-related activities and initiatives during the review period:</p> <ol style="list-style-type: none"> 1. A new psychiatrist was hired to lead Substance Use Services at PSH. This psychiatrist is well qualified in the field and suited for this assignment.

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		<p>2. The facility reported that an additional 53 providers of Substance Abuse groups were trained in the trans-theoretical model of stages of change and certified to provide treatment in the Mall for a total of 243 providers. (See C.2.q for note on this total.) This total ensures that each WRPT has a trained and certified provider. However, a number of these providers were not available to provide Mall groups during this review period due to staff changes, including attrition and shifting to nocturnal schedules. In the current period, approximately 125-140 of these staff were reportedly available to serve as facilitators or co-facilitators in substance abuse Mall groups in any given month.</p> <p>3. All individuals at PSH with substance-related disorders on Axis I were staged by the Substance Abuse Assessment Team (SAAT) in March 2010. The results for Focus 5 staging were communicated to the WRTs to consider when referring individuals for treatment in the Mall.</p> <p>4. A complete Mall Catalogue of different Substance Abuse recovery groups was developed and is available in the respective Mall offices. Groups and curriculums are stratified based on the stage of change and cognitive functioning.</p> <p>5. Starting in September 2009, the SAAT organized an outreach to Programs to help identify problem cases, including those who trigger with positive urine drug screens, and to facilitate referrals and placement of individuals with substance-related diagnoses into appropriate groups.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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<p>C.2.o</p>	<p>Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Provide summary of both process and clinical outcome data regarding delivery of substance use services.</p> <p>Findings: The following is a summary of PSH's process outcome data:</p> <table border="1" data-bbox="991 522 1843 1386"> <thead> <tr> <th></th> <th>Jul-Sep 2009</th> <th>Jan-Feb 2010</th> </tr> </thead> <tbody> <tr> <td>Process Outcomes</td> <td></td> <td></td> </tr> <tr> <td>Individuals with Substance Abuse Dx</td> <td>1002</td> <td>1027</td> </tr> <tr> <td>Individuals screened for SAS treatment</td> <td>972</td> <td>955</td> </tr> <tr> <td> Screen Refusals</td> <td>282</td> <td>388</td> </tr> <tr> <td> Pre-contemplation</td> <td>273</td> <td>141</td> </tr> <tr> <td> Contemplation</td> <td>184</td> <td>140</td> </tr> <tr> <td> Preparation</td> <td>116</td> <td>151</td> </tr> <tr> <td> Action</td> <td>91</td> <td>90</td> </tr> <tr> <td> Maintenance</td> <td>26</td> <td>45</td> </tr> <tr> <td> Monolingual Spanish</td> <td>30</td> <td>31</td> </tr> <tr> <td>Hours of SAS treatment offered/week</td> <td>451</td> <td>450</td> </tr> <tr> <td>SAS sessions scheduled</td> <td>365</td> <td>322</td> </tr> <tr> <td>SAS sessions held</td> <td>347/95%</td> <td>313/97%</td> </tr> <tr> <td>AA/NA sessions held</td> <td>74/99%</td> <td>70/91%</td> </tr> <tr> <td>Individuals enrolled in SAS treatment</td> <td>972</td> <td>955</td> </tr> <tr> <td> Pre-contemplation</td> <td>387</td> <td>278</td> </tr> <tr> <td> Contemplation</td> <td>262</td> <td>238</td> </tr> <tr> <td> Preparation</td> <td>165</td> <td>210</td> </tr> <tr> <td> Action</td> <td>126</td> <td>153</td> </tr> <tr> <td> Maintenance</td> <td>39</td> <td>76</td> </tr> <tr> <td> Monolingual Spanish</td> <td>28</td> <td>25</td> </tr> <tr> <td>Individuals enrolled in AA/NA</td> <td>75</td> <td>77</td> </tr> </tbody> </table>		Jul-Sep 2009	Jan-Feb 2010	Process Outcomes			Individuals with Substance Abuse Dx	1002	1027	Individuals screened for SAS treatment	972	955	Screen Refusals	282	388	Pre-contemplation	273	141	Contemplation	184	140	Preparation	116	151	Action	91	90	Maintenance	26	45	Monolingual Spanish	30	31	Hours of SAS treatment offered/week	451	450	SAS sessions scheduled	365	322	SAS sessions held	347/95%	313/97%	AA/NA sessions held	74/99%	70/91%	Individuals enrolled in SAS treatment	972	955	Pre-contemplation	387	278	Contemplation	262	238	Preparation	165	210	Action	126	153	Maintenance	39	76	Monolingual Spanish	28	25	Individuals enrolled in AA/NA	75	77
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		<p>In March 2010, PSH replaced the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) with another measure, the Readiness Ruler (RR) instrument. The newer tool was selected due to a number of factors indicating that it may be a more feasible instrument for the facility's population, in addition to literature demonstrating its predictive validity. PSH presented results of a study conducted by Dr. Meyer, the new psychiatric leader of substance use services. The study compared the stages of change identified by the SOCRATES measure compared to the RR. The results showed slight differences in the stages of change depending on the instrument used. For that reason, the data regarding individuals' progression in the stages of change, as a clinical outcome, were deferred for this review period. A database was created in March 2010 that included the RR data, as well as demographic and diagnostic data available in the DMH database. The construction of this database should permit longitudinal data extraction on clinical SA outcomes, with the March 2010 RR data serving as the baseline.</p> <p>Based on a review of the facility's current data regarding individuals identified in each stage of change, this monitor found that that PSH has maintained progress in helping individuals advance in their readiness for change.</p> <p>The facility presented Consumer Satisfaction Survey data based on 200 randomly selected individuals attending substance abuse groups. The format of presenting the results was modified from the last review. The following is a summary of the results of this survey (May 2010) compared to obtained from the most recent prior survey (November 2009)</p> <table border="1" data-bbox="989 1226 1890 1412"> <thead> <tr> <th data-bbox="989 1226 1507 1300">Consumer Satisfaction Survey</th> <th data-bbox="1507 1226 1698 1300">Nov 2009</th> <th data-bbox="1698 1226 1890 1300">May 2010</th> </tr> </thead> <tbody> <tr> <td data-bbox="989 1300 1507 1412">1. Overall satisfaction with the information and skills provided by the group</td> <td data-bbox="1507 1300 1698 1412"></td> <td data-bbox="1698 1300 1890 1412"></td> </tr> </tbody> </table>	Consumer Satisfaction Survey	Nov 2009	May 2010	1. Overall satisfaction with the information and skills provided by the group		
Consumer Satisfaction Survey	Nov 2009	May 2010						
1. Overall satisfaction with the information and skills provided by the group								

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		<ul style="list-style-type: none"> • Excellent 	49%	50%
		<ul style="list-style-type: none"> • Good 	36%	31%
		<ul style="list-style-type: none"> • Adequate 	12%	12%
		<ul style="list-style-type: none"> • Minimal 	2%	4%
		<ul style="list-style-type: none"> • Poor 	2%	3%
		2. The instructor demonstrated knowledge of the course subject		
		<ul style="list-style-type: none"> • Excellent 	55%	47%
		<ul style="list-style-type: none"> • Good 	29%	35%
		<ul style="list-style-type: none"> • Adequate 	14%	11%
		<ul style="list-style-type: none"> • Minimal 	2%	4%
		<ul style="list-style-type: none"> • Poor 	1%	3%
		3. The group resulted in change of the way I see substance use		
		<ul style="list-style-type: none"> • Strongly agree 	50%	38%
		<ul style="list-style-type: none"> • Agree 	25%	38%
		<ul style="list-style-type: none"> • Neutral 	17%	10%
		<ul style="list-style-type: none"> • Disagree 	4%	8%
		<ul style="list-style-type: none"> • Strongly disagree 	4%	6%
		4. The group resulted in change of the way I see myself		
		<ul style="list-style-type: none"> • Strongly agree 	50%	39%
		<ul style="list-style-type: none"> • Agree 	24%	32%
		<ul style="list-style-type: none"> • Neutral 	17%	17%
		<ul style="list-style-type: none"> • Disagree 	6%	7%
		<ul style="list-style-type: none"> • Strongly disagree 	4%	5%
		<p>Recommendation 2, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>		

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		<p>Findings: Using the DMH Substance Abuse Auditing Form, PSH assessed its compliance with this requirement based on an average sample of 21% of individuals with a current diagnosis of substance abuse (November 2009-April 2010):</p> <table border="1" data-bbox="991 414 1887 938"> <tr> <td>1.</td> <td><i>Substance abuse is integrated into the case formulation and discussed in the present status.</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>There is an appropriate focus statement listed under Focus 5.</i></td> <td>91%</td> </tr> <tr> <td>3.</td> <td><i>There is at least one objective related to the individual's stage of change.</i></td> <td>91%</td> </tr> <tr> <td>4.</td> <td><i>There are interventions that are appropriately linked to the active objective(s).</i></td> <td>96%</td> </tr> <tr> <td>5.</td> <td><i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i></td> <td>90%</td> </tr> </table> <p>Comparative data indicated improvement in compliance since the previous review period:</p> <table border="1" data-bbox="991 1084 1887 1388"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td>1.</td> <td>94%</td> <td>96%</td> </tr> <tr> <td>2.</td> <td>81%</td> <td>91%</td> </tr> <tr> <td>3.</td> <td>74%</td> <td>91%</td> </tr> <tr> <td>4.</td> <td>84%</td> <td>96%</td> </tr> <tr> <td>5.</td> <td>78%</td> <td>99%</td> </tr> </tbody> </table>	1.	<i>Substance abuse is integrated into the case formulation and discussed in the present status.</i>	96%	2.	<i>There is an appropriate focus statement listed under Focus 5.</i>	91%	3.	<i>There is at least one objective related to the individual's stage of change.</i>	91%	4.	<i>There are interventions that are appropriately linked to the active objective(s).</i>	96%	5.	<i>The active treatment for substance abuse that is specified in the WRP is aligned with the individual's Mall schedule.</i>	99%	6.	<i>The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms.</i>	90%		Previous period	Current period	Mean compliance rate			1.	94%	96%	2.	81%	91%	3.	74%	91%	4.	84%	96%	5.	78%	99%
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		6.	57%	90%												
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.	<p>Other findings: This monitor reviewed the charts of six individuals to assess the proper identification of the individual's stage of change regarding substance use treatment and the development of objectives and interventions that are appropriately linked to the stages. As mentioned in C.2.f.iv, this review found substantial compliance in five charts (KKE, MVL, NB, SPE and WM) and partial compliance in one (WGA).</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide summary of both process and clinical outcome data regarding delivery of substance use services. 2. Continue to monitor this requirement. <p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Mall Facilitator Observation Monitoring Form, PSH assessed its compliance based on an average sample of 13% of the clinical facilitators managing groups each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1268 1883 1414"> <thead> <tr> <th></th> <th></th> <th>Previous review period</th> <th>Current review period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Instructional skills</i></td> <td>93%</td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>Course structure</i></td> <td>92%</td> <td>90%</td> </tr> </tbody> </table>					Previous review period	Current review period	1.	<i>Instructional skills</i>	93%	97%	2.	<i>Course structure</i>	92%	90%
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1.	<i>Instructional skills</i>	93%	97%													
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		3.	<i>Instructional techniques</i>	97%	94%
		4.	<i>Learning process</i>	92%	96%
		<p>Using the DMH Mall Facilitator Observation Monitoring Form PSH assessed compliance from observation of a 13% sample of all facilitators during the review months (November 2009-April 2010):</p>			
		1.	<i>Session starts and ends within 5 minutes of the designated starting and ending time.</i>	79%	
		2.	<i>Facilitator greets participants to begin the session.</i>	98%	
		3.	<i>There is a brief review of work from prior session.</i>	91%	
		4.	<i>Facilitator introduces the day's topic and goals.</i>	94%	
		5.	<i>Facilitator shows familiarity with lesson plan either verbally or as demonstrated during the group session.</i>	95%	
		6.	<i>Facilitator attempts to engage each participant in the session.</i>	97%	
		7.	<i>Facilitator attempts to keep all participants "on task" during the session.</i>	99%	
		8.	<i>Facilitator shows a presentation style that keeps some/all participants attentive and interested during the session.</i>	99%	
		9.	<i>Facilitator attempts to test the participants understanding.</i>	96%	
		10.	<i>Facilitator presents information in a manner appropriate to the functioning level of the participants.</i>	100%	
		11.	<i>The facilitator summarizes the work done in the session.</i>	88%	
		12.	<i>Facilitator/Co-facilitator used at least one of the following: modeling, prompting and coaching, positive reinforcement, shaping, behavioral rehearsal/role play, homework, or multimedia instruction.</i>	97%	

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		<table border="1"> <tr> <td>13.</td> <td><i>The room is arranged in a way that is as conducive to learning as possible.</i></td> <td>91%</td> </tr> </table>	13.	<i>The room is arranged in a way that is as conducive to learning as possible.</i>	91%																					
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		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for items 2, 4-10, and 12-14; changes were mixed for the remaining items:</p>																								
		<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>90%</td> <td>79%</td> </tr> <tr> <td>3.</td> <td>89%</td> <td>91%</td> </tr> <tr> <td>11.</td> <td>87%</td> <td>88%</td> </tr> <tr> <td colspan="3">Compliance rate in last month of period</td> </tr> <tr> <td>1.</td> <td>89%</td> <td>81%</td> </tr> <tr> <td>11.</td> <td>85%</td> <td>97%</td> </tr> </tbody> </table>		Previous period	Current period	Mean compliance rate			1.	90%	79%	3.	89%	91%	11.	87%	88%	Compliance rate in last month of period			1.	89%	81%	11.	85%	97%
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		<p>Observation of seven Mall groups found that the facilitators were prepared, including the substitute facilitators. All the seven groups had lesson plans, and the facilitators followed the lesson plans of the day in six of the groups. In the remaining group, the facilitators made a good clinical decision to use other lessons given the nature of the individuals attending the groups. Attendance was high in six of the seven groups, and attendance was low in one group because there was a lockdown at that time and individuals were unable to transfer from their units to the Mall area. Two groups did not have their regular facilitators; one group was facilitated by a co-provider and the other by substitute staff. This is an improvement given that in the past, in all likelihood, these groups would have been cancelled in the absence of the primary facilitator. The groups with substitute providers were involved in meaningful activities and not treated as down-time. The quality of the facilitation of the groups ranged from excellent to acceptable.</p>																								

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		<p>Suggestions for further improvement during the maintenance phase:</p> <ol style="list-style-type: none"> 1. Where possible, rearrange the seating to suit the group activities. 2. Plan activities for active participation by individuals, and reduce the "sit and listen" periods. 3. Engage ALL the individuals in the group and not let the few active ones monopolize the group. 4. Reorient the individuals disengaged from the group, call on them to participate, direct questions at them, ask for their assistance in some task, or have the co-facilitator provide some one-on-one facilitation time. 5. Use material and techniques appropriate to the lesson/activity. 6. Most importantly, ensure that the lessons/activities/questions are individualized and made personal to the individual. Individuals attending the Mall group need to feel wanted, listened to, heard from, and hear issues specific to them addressed in addition to learning general information. This could be a motivating factor for them to attend the groups in addition to helping them to make progress in their discharge matters and quality of life. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.q	Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p>

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		<p>Findings: PSH presented the following data regarding the certification of Substance Abuse facilitators:</p> <table border="1" data-bbox="991 337 1873 493"> <thead> <tr> <th></th> <th>Providers</th> <th>Co-providers</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Number</td> <td>68</td> <td>89</td> <td>157</td> </tr> <tr> <td>Number certified</td> <td>62</td> <td>68</td> <td>130</td> </tr> <tr> <td>Percentage certified</td> <td>91%</td> <td>77%</td> <td>83%</td> </tr> </tbody> </table> <p>In the previous review period, the facility reported that 93% of substance abuse groups were led by certified providers (note that this is a different counting methodology and thus is not directly comparable to the 83% reported in the current review period).</p> <p>Note that in C.2.n, the facility reported that 53 additional providers were trained during the review period for a total of 243 certified providers. It is possible that the table above represents only those providers who actually provided Substance Abuse facilitation during the review period.</p> <p>Other findings: See findings in C.2.n.</p> <p>Compliance: Partial.</p> <p>Current recommendation: Ensure that training is provided so that all providers and co-providers are certified.</p>		Providers	Co-providers	Total	Number	68	89	157	Number certified	62	68	130	Percentage certified	91%	77%	83%
	Providers	Co-providers	Total															
Number	68	89	157															
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C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>																

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Findings:

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

Missed Appointments Monitoring - Medical Services					
	Appointments		Reasons for Cancellation		
	Sched- uled	Cancelled	Staffing	Transpor- tation	Other
Nov 09	1636	432	15	6	411
Dec 09	1485	404	29	14	361
Jan 10	1889	376	17	13	346
Feb 10	2131	517	35	7	475
Mar 10	2157	725	8	28	689
Apr 10	2101	557	34	18	505
Total	11,399	3011	138	86	2787

The number of scheduled appointments (11,399) was significantly higher during this review period than in the previous period (2305) and should be re-checked and confirmed because it implies an average of more than seven scheduled appointments per individual during the period, which seems unusual. The cancellation of scheduled appointments due to staffing and transportation issues was 7% during this review period and 4% during the previous period. According to the Director of Standards Compliance, the facility is reviewing the causes for cancellations due to staffing and transportation. PSH should also analyze the reasons for

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		<p>refusals and provide support to the individuals to keep their scheduled appointments (for example, desensitization procedures for anxiety, schedule appointments when individual does not have important/interesting competing activities or ensure the individual gets to engage in the activity when he/she returns from the appointment; and/or allocate By Choice points for keeping the schedules).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
C.2.s	<p>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Ensure that individuals' cognitive levels, needs and strengths are utilized when considering group assignments.</p> <p>Findings: See C.2.i.vi.</p> <p>Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1154 1892 1414"> <tr> <td data-bbox="991 1154 1087 1414">10.</td> <td data-bbox="1087 1154 1795 1414"><i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and</i></td> <td data-bbox="1795 1154 1892 1414">97%</td> </tr> </table>	10.	<i>Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate 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</i>	97%
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		<table border="1" data-bbox="991 190 1892 305"> <tr> <td data-bbox="991 190 1094 305"></td> <td data-bbox="1094 190 1795 305"> <p><i>substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></p> </td> <td data-bbox="1795 190 1892 305"></td> </tr> </table> <p>Comparative data indicated improvement in compliance from 88% in the previous review period.</p> <p>A review of the WRPs for seven individuals found that six of the WRPs had assigned the individuals to meaningful groups in line with their diagnoses and cognitive levels (CSC, DLJ, JAH, JLO, MLB and RDW). The remaining one (RNM) did not.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<p><i>substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></p>	
	<p><i>substance abuse are appropriately addressed, consistent with generally accepted professional standards of care.</i></p>				
C.2.t	<p>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Ensure that WRPTs review PSH Mall Facilitator Monthly Progress Notes, document individual progress or lack thereof, and discuss the findings with the individual. • 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. <p>Findings: Using the DMH WRP Clinical Chart Auditing Form, PSH assessed its compliance based on an average sample of 11% of the WRPs due each month during the review period (November 2009-April 2010):</p>			

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		11.	<i>Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant development, and the individual's progress, or lack thereof.</i>	86%
		11.a	<i>Each objective is observable, measurable and behavioral.</i>	97%
		11.b	<i>All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual's WRP.</i>	99%
		11.c	<i>There is a DMH PSR Mail Facilitator Monthly Progress Note for each active treatment in the individual's WRP.</i>	77%
		11.d	<i>If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.</i>	64%
		11.e	<i>If the individual has met the objective, a new objective and related interventions have been developed and implemented.</i>	96%
Comparative data indicated mixed changes in compliance since the previous review period:				
			Previous period	Current period
Mean compliance rate				
11.			65%	86%
Compliance rate in last month of period				
11.			80%	90%
11.a			94%	98%

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		<table border="1"> <tr> <td>11.b</td> <td>97%</td> <td>100%</td> </tr> <tr> <td>11.c</td> <td>55%</td> <td>89%</td> </tr> <tr> <td>11.d</td> <td>69%</td> <td>64%</td> </tr> <tr> <td>11.e</td> <td>83%</td> <td>100%</td> </tr> </table>	11.b	97%	100%	11.c	55%	89%	11.d	69%	64%	11.e	83%	100%	<p>The mean compliance rate for item 11.c (77%) does not comport with information in C.2.i.vii, in which the facility reported a 97% compliance rate regarding the completion of Mall progress notes; the facility's report did not resolve this conflict, which may be due to the use of a different time period for each audit.</p> <p>According to PSH, the data for this requirement was obtained from the WaRMSS module, which was put in place only in February 2010. PSH plans to continue to audit and provide feedback to program managers to further improve compliance. According to the Mall Director, it takes time for WRPTs to make Mall group assignments and re-assignments, sometimes as much as an hour using the current software system, especially for staff who have yet to master the operation of this system. PSH had started pilot training on the system using ward clerks to assist WRPTs on two units, and the facility plans to continue this training until all teams get trained.</p> <p>A review of the WRPs for six individuals found that all six WRPs met the elements of this requirement (CSC, DLJ, JLO, MLB, RDW and RNM). Observation of WRPCs (CCH, MT and STJ) found that the teams had incorporated Mall progress notes into the WRP before the session. Information from the Mall notes was discussed at the conference.</p> <p>Compliance: Partial; improved compared to last review. Although the monitor found substantial compliance in all charts reviewed, the facility's sample was significantly larger.</p>
11.b	97%	100%													
11.c	55%	89%													
11.d	69%	64%													
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		<p>Current recommendation: Continue to monitor this requirement.</p>																																		
C.2.u	<p>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to provide data regarding this requirement.</p> <p>Findings: The table below showing the numbers of individuals needing and receiving WRP education is a summary of the facility's data:</p> <table border="1" data-bbox="991 638 1852 865"> <thead> <tr> <th colspan="5">Number of the Introduction to Wellness and Recovery groups offered during the current and previous three Fall terms</th> </tr> <tr> <th></th> <th>Jul-Sep 2009</th> <th>Oct-Dec 2009</th> <th>Jan-Mar 2010</th> <th>April 5-30, 2010</th> </tr> </thead> <tbody> <tr> <td>Needing</td> <td>246</td> <td>264</td> <td>285</td> <td>71</td> </tr> <tr> <td>Receiving</td> <td>246</td> <td>264</td> <td>285</td> <td>71</td> </tr> </tbody> </table> <p>The table above indicates that PSH has provided Wellness and Recovery Education groups to all individuals in need of the program.</p> <table border="1" data-bbox="991 1013 1873 1354"> <thead> <tr> <th colspan="2">Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (November 2009-April 2010, mean)</th> </tr> </thead> <tbody> <tr> <td>Sessions scheduled</td> <td>92</td> </tr> <tr> <td>Sessions held</td> <td>92</td> </tr> <tr> <td>% held</td> <td>100</td> </tr> <tr> <td>Individuals scheduled</td> <td>77</td> </tr> <tr> <td>Individuals attended at least one group per month</td> <td>77</td> </tr> <tr> <td>% attended</td> <td>100</td> </tr> </tbody> </table>	Number of the Introduction to Wellness and Recovery groups offered during the current and previous three Fall terms						Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	April 5-30, 2010	Needing	246	264	285	71	Receiving	246	264	285	71	Number of Introduction to Wellness and Recovery Groups Scheduled and Attended (November 2009-April 2010, mean)		Sessions scheduled	92	Sessions held	92	% held	100	Individuals scheduled	77	Individuals attended at least one group per month	77	% attended	100
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		<p>Recommendation 2, June 2009: Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment.</p> <p>Findings: All seven WRPs reviewed contained documentation indicating whether or not a copy of the report was given to the individual (CCK, GM, HJA, IJ, JS, MLD and SLC).</p> <p>This monitor observed three WRPCs (CCH, MT and STJ). In all three cases, the WRPT members considered giving a copy of the WRP to the individual or made a clinical decision not to do so.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data regarding the number of individuals identified as in need of a medication education group, the number of individuals scheduled for a medication education group, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</p> <p>Findings: The following is a summary of the facility's data:</p>

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		<table border="1" data-bbox="991 228 1887 493"> <thead> <tr> <th colspan="4" data-bbox="991 228 1887 266">Individuals Needing and Provided Medication Education Groups</th> </tr> <tr> <th data-bbox="991 266 1218 303"></th> <th data-bbox="1218 266 1440 303">Jul-Sep 2009</th> <th data-bbox="1440 266 1665 303">Oct-Dec 2009</th> <th data-bbox="1665 266 1887 303">Jan-Mar 2010</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 303 1218 380"># of individuals needing service</td> <td data-bbox="1218 303 1440 380">1,062</td> <td data-bbox="1440 303 1665 380">1,067</td> <td data-bbox="1665 303 1887 380">1,057</td> </tr> <tr> <td data-bbox="991 380 1218 493"># of individuals receiving service</td> <td data-bbox="1218 380 1440 493">959</td> <td data-bbox="1440 380 1665 493">957</td> <td data-bbox="1665 380 1887 493">968</td> </tr> </tbody> </table> <p data-bbox="991 537 1927 751">Other findings: This monitor interviewed Andrew Blaine, MD, Staff Psychiatrist responsible for the medication education of individuals and reviewed the facility's Medication Education Assessment Tool. The interview and review found that the current system of needs assessment of the individuals was adequate.</p> <p data-bbox="991 797 1927 862">Compliance: Substantial.</p> <p data-bbox="991 907 1927 1122">Current recommendation: Provide data regarding the number of individuals identified as in need of a medication education group, the number of individuals scheduled for a medication education group, the number of groups offered and the number of hours offered. Provide comparative data from the previous to current review period for each data element.</p>	Individuals Needing and Provided Medication Education Groups					Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010	# of individuals needing service	1,062	1,067	1,057	# of individuals receiving service	959	957	968
Individuals Needing and Provided Medication Education Groups																		
	Jul-Sep 2009	Oct-Dec 2009	Jan-Mar 2010															
# of individuals needing service	1,062	1,067	1,057															
# of individuals receiving service	959	957	968															
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	<p data-bbox="991 1166 1927 1198">Current findings on previous recommendations:</p> <p data-bbox="991 1243 1927 1276">Recommendations 1 and 2, December 2009:</p> <ul data-bbox="991 1276 1927 1416" style="list-style-type: none"> <li data-bbox="991 1276 1927 1349">• Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability. <li data-bbox="991 1349 1927 1416">• Refine the non-adherent trigger criteria differentiating non-adherence due to motivation from non-adherence due to other issues 																

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		<p>including medical and mental illness.</p> <p>Findings: The table below showing the number of individuals meeting the non-adherence criteria for 30 consecutive days in each month of this review period is a summary of the facility's data:</p> <table border="1" data-bbox="991 451 1906 625"> <thead> <tr> <th>2009/10</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Nonadherence for 30 consecutive days</td> <td>13</td> <td>7</td> <td>5</td> <td>2</td> <td>4</td> <td>3</td> <td>6</td> </tr> </tbody> </table> <p>The above mean implies that approximately 1% of individuals were non-adherent to treatment. In the previous review period, the facility reported that 1,311 individuals (89%) were non-adherent. That data was believed to be suspect as it apparently included individuals who did not attend Mall groups due to physical incapacitation or symptoms of mental illness that precluded participation. Nevertheless, this is a drastic decline in non-adherence. The facility did not describe in its progress report the changes to its non-adherence measurement methodology that would explain this decline.</p> <p>Recommendation 3, December 2009: 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.</p> <p>Findings: The facility's presented the following data regarding methods used to encourage adherence to treatment:</p>	2009/10	Nov	Dec	Jan	Feb	Mar	Apr	Mean	Nonadherence for 30 consecutive days	13	7	5	2	4	3	6
2009/10	Nov	Dec	Jan	Feb	Mar	Apr	Mean											
Nonadherence for 30 consecutive days	13	7	5	2	4	3	6											

Section C: Integrated Therapeutic and Rehabilitation Services Planning

	1.	Motivational Interviewing	9
	2.	Changing groups	15
	3.	Individual Therapy	10
	4.	Medication changes	12
	5	Motivational Enhancement Group	5
	6	By Choice point reallocation	4
	7	Behavior Guidelines	3
	8	CBT	3
	9	DBT	1
	10	RISE	2
	11	SAFE	1
<p>As the table above shows, PSH is using a variety of behavior change methods with individuals unmotivated to regularly attend Mall groups. The treatment selection is specific to the reasons for the individual's non-adherence. At the next review, the facility should be prepared to present evidence of the effectiveness of these behavioral treatments.</p> <p>Staff interviews and documentation reviews found that PSH had trained 24 clinicians on Motivational Interviewing during this review period. The facility also had conducted a one-day mandated training on Motivational Interviewing for all Psychologists, Social Workers, and Rehabilitation Therapists. The training was also attended by a number of psychiatrists, nursing staff and dieticians. PSH has trained a total of 366 staff on Motivational Interviewing.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Present data regarding the number of individuals who were non-adherent to WRP and improve data reliability. 			

Section C: Integrated Therapeutic and Rehabilitation Services Planning

		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.
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Section D: Integrated Assessments

D. Integrated Assessments		
D	<p>Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.</p>	<p>Summary of Progress on Psychiatric Assessments and Diagnoses:</p> <ol style="list-style-type: none"> 1. The facility has maintained substantial compliance with the requirements in cells D.1.a (use of diagnostic criteria), D.1.c regarding the admission medical, admission psychiatric and integrated psychiatric assessments, and D.1.e regarding the timeliness of psychiatric reassessments. 2. PSH has achieved substantial compliance with the requirements in cell D.1.f regarding the content of psychiatric reassessments. 3. PSH has made significant progress in meeting the requirement in cell D.1.g regarding the content of psychiatric inter-unit transfer assessments <p>Summary of Progress on Psychological Assessments: PSH has maintained substantial compliance with all requirements of Section D.2.</p> <p>Summary of Progress on Nursing Assessments: PSH has maintained substantial compliance with all requirements of Section D.3 and continues to produce quality admission and integrated nursing assessments.</p> <p>Summary of Progress on Rehabilitation Therapy Assessments: PSH has maintained substantial compliance overall with the requirements of Section D.4 and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Assessments: PSH has maintained substantial compliance with the requirements of Section D.5 with the exception of the sub-item of timeliness of lower-acuity assessments (cells D.5.i. and D.5.j.ii).</p>

Section D: Integrated Assessments

		<p>Summary of Progress on Social History Assessments: PSH has maintained substantial compliance with all requirements of Section D.6.</p> <p>Summary of Progress on Court Assessments: As of the tour conducted in June 2009, PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it is the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.</p>
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Section D: Integrated Assessments

1. Psychiatric Assessments and Diagnoses		
	<p>Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,</p>	<p>Methodology:</p> <p><u>Interviewed:</u> Rebecca Kornbluh, MD, Acting Chief of Psychiatry</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 34 individuals: BC, CH, CRH, CSA, DJU, DLJ, DM, EAL, ET, FJ, GB, IS, JAL, JNP, KKE, LJ, LLL, MLR, MLV, MSB, MVV, NAC, NB, OV, PAS, RH, SFA, SR, TG, TNH, TW, VM, VQ and WHS 2. Template Integrated Assessment; Psychology Section (IAPS) 3. Monthly Psychiatric Progress Notes for the following 52 individuals: ALT, BEK, BG, CB, CBA, CGG, CH, CWL, DF-1, DF-2, DRH, DTJ, DW, ER, ETR, GH, HLG, JAL, JAM, JH-1, JH-2, JKO, JS, KC, KMS, LGM, LJS, LL, LW, MB, MLB, MMS, MOC, MV, NC, NNT, PC, PEL, PLH, RA, RAP, RC, RGM, RH, RM, RS, SC, SH, TCS, TLM, TS-1 and TS-2 4. PSH Admission Psychiatric Assessment summary data (November 2009-April 2010) 5. PSH Integrated Assessment: Psychiatric Section summary data (November 2009-April 2010) 6. PSH Admission Medical Assessment Auditing summary (November 2009-April 2010) 7. PSH Monthly PPN Audit summary data (November 2009-April 2010) 8. PSH Weekly PPN Auditing summary data (November 2009-April 2010) 9. PSH Physician Transfer Note Auditing summary (November 2009-April 2010)
D.1.a	<p>Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>

Section D: Integrated Assessments

		<p>Findings:</p> <p>PSH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Auditing Forms to assess compliance for the review period (November 2009-April 2010). The average samples were 48% of admission assessments, 25% of integrated assessments and 21 % of monthly notes on individuals who have been hospitalized for more than 90 days. The following tables summarize the data:</p> <table border="1" data-bbox="991 487 1890 565"> <thead> <tr> <th colspan="3">Admission Assessment</th> </tr> </thead> <tbody> <tr> <td>4.</td> <td><i>Admission diagnoses are documented.</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 711 1890 1091"> <thead> <tr> <th colspan="3">Integrated Assessment</th> </tr> </thead> <tbody> <tr> <td>2.b</td> <td><i>If applicable, statements from the individual are included or a comment addressing this and a plan to obtain the lacking information.</i></td> <td>100%</td> </tr> <tr> <td>2.d</td> <td><i>Psychiatric history, including review of present and past history including diagnosis and medications given at previous facility.</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Includes diagnostic formulation.</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Includes differential diagnosis</i></td> <td>98%</td> </tr> <tr> <td>9.</td> <td><i>Includes current psychiatric diagnoses.</i></td> <td>100%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <table border="1" data-bbox="991 1237 1890 1354"> <thead> <tr> <th colspan="3">Monthly PPN</th> </tr> </thead> <tbody> <tr> <td>3.b</td> <td><i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i></td> <td>97%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of</p>	Admission Assessment			4.	<i>Admission diagnoses are documented.</i>	100%	Integrated Assessment			2.b	<i>If applicable, statements from the individual are included or a comment addressing this and a plan to obtain the lacking information.</i>	100%	2.d	<i>Psychiatric history, including review of present and past history including diagnosis and medications given at previous facility.</i>	99%	7.	<i>Includes diagnostic formulation.</i>	98%	8.	<i>Includes differential diagnosis</i>	98%	9.	<i>Includes current psychiatric diagnoses.</i>	100%	Monthly PPN			3.b	<i>Timely and justifiable updates of diagnosis and treatment, as clinically indicated.</i>	97%
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Section D: Integrated Assessments

		<p>at least 90% from the previous review period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																		
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.																		
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The facility has maintained its practice. The following is a summary of the data regarding the number and type of positions:</p> <table border="1" data-bbox="991 971 1776 1216"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Psychiatric positions filled</td> <td></td> <td></td> </tr> <tr> <td>FTE psychiatrists</td> <td>88</td> <td>85</td> </tr> <tr> <td>FTE direct care psychiatrists</td> <td>69</td> <td>74</td> </tr> <tr> <td>Board-certified</td> <td>52</td> <td>50</td> </tr> <tr> <td>Board-eligible</td> <td>40</td> <td>34</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p>		Previous period	Current period	Psychiatric positions filled			FTE psychiatrists	88	85	FTE direct care psychiatrists	69	74	Board-certified	52	50	Board-eligible	40	34
	Previous period	Current period																		
Psychiatric positions filled																				
FTE psychiatrists	88	85																		
FTE direct care psychiatrists	69	74																		
Board-certified	52	50																		
Board-eligible	40	34																		

Section D: Integrated Assessments

		<p>Current recommendation: Continue current practice.</p>
D.1.b.ii	<p>Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide summary regarding status of implementation of the [process described in this cell in the previous report].</p> <p>Findings: The facility has implemented this process. The following is a summary of items upon which privileging/reprivileging is contingent:</p> <ul style="list-style-type: none"> • Satisfactory attendance at Departmental meetings; • Licensure status; • Malpractice or medical board findings; • Timeliness of assessments; • Prescribing errors; • Surgical morbidity/mortality findings; • Appropriate utilization management; • Professional conduct; and • Results of DMH audit. <p>Compliance: Substantial.</p> <p>Current recommendation: Provide summary regarding status of implementation of the current process of reprivileging.</p>
D.1.c	<p>Each State hospital shall ensure that:</p>	<p>Please see sub-cells for compliance findings.</p>

Section D: Integrated Assessments

<p>D.1.c.i</p>	<p>Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure that the neurological examination of deep tendon reflexes is completed consistently. <p>Findings: Using the DMH Admission Medical Assessment Monitoring Form, PSH assessed its compliance with the requirements of D.1.c.i.1 through D.1.c.1.5 based on an average sample of 78% of admissions each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 673 1885 784"> <tr> <td data-bbox="991 673 1087 784">1.</td> <td data-bbox="1087 673 1793 784"><i>Within 24 hours of an individual's admission to each State Hospital, the individual receives an Admission Medical Assessment.</i></td> <td data-bbox="1793 673 1885 784">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Other findings: A review of the charts of 10 individuals admitted during the review period (BC, DJU, ET, KKE, LJ, NAC, NB, OV, TG and WHS) found substantial compliance in nine charts and partial compliance in one (OV). In the chart of OV, the neurological examination was done after initial refusal by the individual, but the examination was incomplete.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Within 24 hours of an individual's admission to each State Hospital, the individual receives an Admission Medical Assessment.</i>	100%
1.	<i>Within 24 hours of an individual's admission to each State Hospital, the individual receives an Admission Medical Assessment.</i>	100%			

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D.1.c.i.1	a review of systems;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.						
D.1.c.i.2	medical history;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.						
D.1.c.i.3	physical examination;	<table border="1"> <tr> <td>4.</td> <td><i>A physical examination</i></td> <td>98%</td> </tr> <tr> <td>5.</td> <td><i>A rectal and genital examination</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that improvement in compliance from 87% in the previous review period for item 4 and 84% for item 5.</p>	4.	<i>A physical examination</i>	98%	5.	<i>A rectal and genital examination</i>	100%
4.	<i>A physical examination</i>	98%						
5.	<i>A rectal and genital examination</i>	100%						
D.1.c.i.4	diagnostic impressions; and	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.						
D.1.c.i.5	management of acute medical conditions	<table border="1"> <tr> <td>7.</td> <td><i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary care physician.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that improvement in compliance from 88% in the previous review period for item 7 and maintenance of a compliance rate of at least 90% for item 8.</p>	7.	<i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary care physician.</i>	100%	8.	<i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i>	100%
7.	<i>Management of acute medical conditions as listed in section E and D are identified and appropriately treated and/or referred for follow-up by primary care physician.</i>	100%						
8.	<i>Further plan of care, preventive health screening and health maintenance if interventions and follow-up that need to be addressed by primary care physician and the attending psychiatrist are checked.</i>	100%						
D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that	Current findings on previous recommendations:						

Section D: Integrated Assessments

	<p>includes:</p>	<p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure consistent documentation of necessary information in the history of present illness as well as specific description of the nature of disturbances of thought content in all cases. <p>Findings: Using the DMH Admission Psychiatric Assessment Audit, PSH assessed its compliance based on an average sample of 48% of admissions each month during the review period (November 2009-April 2010). The mean compliance rate was 100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the requirements in D.1.c.ii.2 through D.1.c.ii.6 are listed for each corresponding cell below. The comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of 10 individuals (BC, DJU, ET, KKE, LJ, NAC, NB, OV, TG and WHS) found substantial compliance in nine charts and partial compliance in one (NAC). In the chart of NAC, the violence risk assessment was inadequately completed (after the initial attempt to complete the assessment was hampered by the individual's muteness).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.ii.1	<p>psychiatric history, including a review of presenting symptoms;</p>	<p>100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>

Section D: Integrated Assessments

D.1.c.ii.2	complete mental status examination;	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.3	admission diagnoses;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.4	completed AIMS;	98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.5	laboratory tests ordered;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.6	consultations ordered; and	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.ii.7	plan of care.	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	<p>Current findings on previous recommendations:</p> <p>Recommendations 1-3, December 2009:</p> <ul style="list-style-type: none"> • Continue to monitor this requirement. • Ensure that the strength formulation is consistently focused on the individual's positive attributes and does not include negative traits. • Ensure that the diagnostic formulation is consistently focused on the diagnosis and is not confused with the interdisciplinary case formulation. <p>Findings: Using the DMH Integrated Assessment Psychiatry Section Audit, PSH assessed its compliance based on an average sample of 25% of Integrated Assessments due each month during the review period (November 2009-April 2010). The mean compliance rate was 97%. Comparative data</p>

Section D: Integrated Assessments

		<p>indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The mean compliance rates for the remaining requirements in D.1.c.iii are listed in each corresponding cell below. Comparative data are listed, as appropriate.</p> <p>Other findings: A review of the charts of 10 individuals found substantial compliance in all cases (BC, DJU, ET, KKE, LJ, NAC, NB, OV, TG and WHS).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.c.iii. 1	psychiatric history, including a review of present and past history;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 2	psychosocial history;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 3	mental status examination;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 4	strengths;	98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 5	psychiatric risk factors;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii.	diagnostic formulation;	98%. Comparative data indicated that PSH has maintained a compliance

Section D: Integrated Assessments

6		rate of at least 90% from the previous review period.
D.1.c.iii. 7	differential diagnosis;	98%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 8	current psychiatric diagnoses;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 9	psychopharmacology treatment plan; and	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.c.iii. 10	management of identified risks.	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Continue to provide documentation of continuing medical education to psychiatry staff to improve competence in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees.</p> <p>Findings: The facility provided an outline of CME presentations (live and video) during this review period. The presentations that were relevant to this recommendation included the following topics:</p> <ol style="list-style-type: none"> 1. Evaluation of Acute Change of Mental Status; 2. Integrated Medical, Psychiatric and Psychological Approaches to Management of Water Intoxication in a Long Term Psychiatric

Section D: Integrated Assessments

		<p>Facility;</p> <ol style="list-style-type: none"> 3. Epilepsy in the New Millennium: Emerging Treatments and Guidelines for Effective Diagnosis and Disease Management; 4. Management of Multiple Sclerosis, Differential Diagnosis - A Consensus Approach; 5. Evolving Sleep-Wake Research: Implications for Improved Patient Outcomes; and 6. Complex Presentations of Sleep-Wake Dysfunction: Case Challenges. <p>Other significant presentations included the following:</p> <ol style="list-style-type: none"> 1. Assessing Competency to Stand Trial; 2. California Insanity Acquittees: Commitment, Extension and Release Issues; 3. Mentally Disordered Offenders: Assessment and Release Issues; 4. He's Such a Nice Guy; He's Got To Be Ready To Go. Right?; 5. Recovery and Integration: Conditional vs. Unconditional Release; 6. Informed Consent, Substituted Medical Consent and California Conservatorships; 7. Involuntary Medication Administration at Patton: Legal and Clinical Considerations; 8. Surviving the Witness Stand; 9. Assessing and Managing the Patient with Bipolar Mania; 10. Improving the Care of People with Mental Illness in Rural Areas; 11. ADHD Case Challenge; 12. Applying Performance Measures through a Chronic Disease Model to Optimize Treatment of Bipolar Mania; 13. ADHD Across the Ages: Focus on the Adult; 14. Bipolar Mania: Improving Recognition, Diagnostic Accuracy and Evidence-Based Treatment; 15. Addressing Barriers to Care: Strategies for the Management of Patients with Schizophrenia; and 16. Child ADHD: Exploring Complexities of Care.
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		<p>The live presentations were, in general, well-attended by the medical staff. No attendance data were available regarding video presentations. The programs were comprehensive in range and well-aligned with the needs of the facility.</p> <p>Recommendation 2, December 2009: Continue to provide comparative data regarding the average number of individuals who have had diagnoses listed as NOS and/or R/O for three or more months during the review period compared with the last period.</p> <p>Findings: PSH reported the comparative number of individuals receiving NOS, Deferred and Rule Out Diagnoses for more than 90 days. The data showed decreases in the number of individuals in all categories from 198 during the previous period to 167 during this review period. In view of the facility's census, these data indicate appropriate practice in this area. However, the facility should report this data stratified by category (NOS, Deferred, and Rule Out).</p> <p>Other findings: This monitor reviewed the charts of the following 12 individuals who have received diagnoses listed as NOS for more than 60 days:</p> <table border="1" data-bbox="989 1078 1879 1421"> <thead> <tr> <th>Initials</th> <th>Diagnosis (NOS)</th> </tr> </thead> <tbody> <tr> <td>CH</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>ET</td> <td>Dementia NOS (finalized to Dementia of the Alzheimer's Type)</td> </tr> <tr> <td>JAL</td> <td>Impulse Control Disorder NOS finalized to Schizophrenia, Paranoid Type</td> </tr> <tr> <td>JNP</td> <td>Impulse Control Disorder NOS</td> </tr> <tr> <td>LLL</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>MLR</td> <td>Psychotic Disorder NOS</td> </tr> </tbody> </table>	Initials	Diagnosis (NOS)	CH	Psychotic Disorder NOS	ET	Dementia NOS (finalized to Dementia of the Alzheimer's Type)	JAL	Impulse Control Disorder NOS finalized to Schizophrenia, Paranoid Type	JNP	Impulse Control Disorder NOS	LLL	Depressive Disorder NOS	MLR	Psychotic Disorder NOS
Initials	Diagnosis (NOS)															
CH	Psychotic Disorder NOS															
ET	Dementia NOS (finalized to Dementia of the Alzheimer's Type)															
JAL	Impulse Control Disorder NOS finalized to Schizophrenia, Paranoid Type															
JNP	Impulse Control Disorder NOS															
LLL	Depressive Disorder NOS															
MLR	Psychotic Disorder NOS															

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		<table border="1" data-bbox="993 190 1879 459"> <tr> <td>MLV</td> <td>Mood Disorder NOS finalized to Schizoaffective Disorder, Depressive Type</td> </tr> <tr> <td>PAS</td> <td>Dementia NOS</td> </tr> <tr> <td>RH</td> <td>Depressive Disorder NOS and Anxiety Disorder NOS</td> </tr> <tr> <td>SR</td> <td>Depressive Disorder NOS</td> </tr> <tr> <td>TW</td> <td>Psychotic Disorder NOS</td> </tr> <tr> <td>VQ</td> <td>Cognitive Disorder NOS</td> </tr> </table> <p data-bbox="993 500 1896 646">Overall, the review found significant improvement in addressing the deficiencies outlined in previous reports, There was evidence of substantial compliance in nine charts (ET, JAL, JNP, LLL, MLR, MLV, RH, SR and TW) and partial compliance in three (CH, PAS and VQ).</p> <p data-bbox="993 686 1140 751">Compliance: Substantial.</p> <p data-bbox="993 800 1325 828">Current recommendations:</p> <ol data-bbox="993 836 1896 1125" style="list-style-type: none"> 1. Continue to provide documentation of continuing medical education to psychiatry staff to improve competence in the assessment of cognitive and other neuropsychiatric disorders. Provide data regarding the title of each program, the speakers and affiliation and the number and disciplines of attendees. 2. Provide stratified data regarding the number of individuals who have had diagnoses listed as NOS, Deferred, and/or R/O for three or more months during the review period compared with the last period. 	MLV	Mood Disorder NOS finalized to Schizoaffective Disorder, Depressive Type	PAS	Dementia NOS	RH	Depressive Disorder NOS and Anxiety Disorder NOS	SR	Depressive Disorder NOS	TW	Psychotic Disorder NOS	VQ	Cognitive Disorder NOS
MLV	Mood Disorder NOS finalized to Schizoaffective Disorder, Depressive Type													
PAS	Dementia NOS													
RH	Depressive Disorder NOS and Anxiety Disorder NOS													
SR	Depressive Disorder NOS													
TW	Psychotic Disorder NOS													
VQ	Cognitive Disorder NOS													
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	<p data-bbox="993 1169 1577 1196">Current findings on previous recommendation:</p> <p data-bbox="993 1245 1434 1310">Recommendation, December 2009: Same as in D.1.d.i.</p> <p data-bbox="993 1359 1213 1421">Findings: Same as in D.1.d.i.</p>												

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		<p>Compliance: Substantial.</p> <p>Current recommendations: Same as in D.1.d.i.</p>
D.1.d.iii	<p>Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and resolved in a clinically justifiable manner; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Same as in D.1.d.i.</p> <p>Findings: Same as in D.1.d.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in D.1.d.i.</p>
D.1.d.iv	<p>"no diagnosis" is clinically justified and documented.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue providing information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results of this review.</p> <p>Findings: The facility reported that no individuals received "No Diagnosis" on Axis I during this review period. This monitor found no evidence of "No Diagnosis" listed on Axis I in any of the charts reviewed.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue providing information regarding the number of individuals who have received "No Diagnosis" on Axis I, review of justification and results of this review.</p>						
D.1.e	<p>Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Weekly Physician Progress Note (PPN) Audit, PSH assessed its compliance based on an average sample of 21% of individuals with length of stay less than 60 days during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 894 1887 971"> <tr> <td data-bbox="991 894 1087 971">1.</td> <td data-bbox="1087 894 1793 971"><i>At a minimum, the reassessments are completed weekly for the first 60 days on the admission units.</i></td> <td data-bbox="1793 894 1887 971">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>PSH also used the DMH Monthly PPN Audit to assess compliance, based on an average sample of 21% of individuals who had been hospitalized for 90 days or more during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1268 1887 1344"> <tr> <td data-bbox="991 1268 1087 1344">1.</td> <td data-bbox="1087 1268 1793 1344"><i>At a minimum, the reassessments are completed monthly on other (than admission) units.</i></td> <td data-bbox="1793 1268 1887 1344">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of</p>	1.	<i>At a minimum, the reassessments are completed weekly for the first 60 days on the admission units.</i>	99%	1.	<i>At a minimum, the reassessments are completed monthly on other (than admission) units.</i>	100%
1.	<i>At a minimum, the reassessments are completed weekly for the first 60 days on the admission units.</i>	99%						
1.	<i>At a minimum, the reassessments are completed monthly on other (than admission) units.</i>	100%						

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		<p>at least 90% from the previous review period.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals (BC, DJU, ET, KKE, LJ, NAC, NB, OV, TG and WHS) who were admitted during this reporting period. The review focused on the timeliness of the notes and found compliance in all cases regarding the weekly reassessments for individuals hospitalized fewer than 60 days and monthly reassessments for individuals hospitalized for 90 or more days.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: PSH used the DMH Monthly PPN Audit to assess compliance, based on an average sample of 21% of individuals who had been hospitalized for 90 days or more. The mean compliance rates for the requirements in D.1.f.i to D.1.f.vii are entered for each corresponding cell below.</p> <p>Other findings: This monitor reviewed the most recent monthly Psychiatric Progress Note for 52 individuals (ALT, BEK, BG, CB, CBA, CGG, CH, CWL, DF-1, DF-2, DRH, DTJ, DW, ER, ETR, GH, HLG, JAL, JAM, JH-1, JH-2, JKO, JS,</p>

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		<p>KC, KMS, LGM, LJS, LL, LW, MB, MLB, MMS, MOC, MV, NC, NNT, PC, PEL, PLH, RA, RAP, RC, RGM, RH, RM, RS, SC, SH, TCS, TLM, TS-1 and TS-2). In general, the review found adequate corrections of the previously identified deficiencies in the documentation of the rationale for continuation of high-risk treatment and in addressing significant laboratory abnormalities and/or results of psychopharmacology consultations in an effort to improve the risk/benefit analysis of current treatment.</p> <p>This monitor reviewed the charts of five individuals (EAL, FJ, MSB, TW and VM) who experienced the use of seclusion and/or restraint during the review period and received PRN/Stat medications in the context of seclusion and/or restraint. This review is also relevant to the requirements in cells D.1.f.vi and F.1.b. The review found substantial compliance in the charts of EAL, FJ, MSB and VM and partial compliance in the chart of TW.</p> <p>Reviewing the charts of three individuals who received PBS (DLG, GB and SFA), this monitor found substantial compliance regarding the integration of psychiatric and behavioral modalities.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	97%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.

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D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	<table border="1" data-bbox="991 228 1887 451"> <tr> <td data-bbox="991 228 1087 451">5.</td> <td data-bbox="1087 228 1793 451"><i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i></td> <td data-bbox="1793 228 1887 451">98%</td> </tr> </table> <p data-bbox="991 493 1904 561">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	98%
5.	<i>Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications.</i>	98%			
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.			
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	<table border="1" data-bbox="991 821 1887 1084"> <tr> <td data-bbox="991 821 1087 1084">5.d</td> <td data-bbox="1087 821 1793 1084"><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td data-bbox="1793 821 1887 1084">95%</td> </tr> </table> <p data-bbox="991 1127 1904 1195">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	95%
5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	95%			
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	99%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.			

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D.1.f.vii	<p>Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.</p>	<p>100%. Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>																					
D.1.g	<p>When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: PSH used the DMH Physician Inter-Unit Transfer Note Audit to assess compliance. The average sample was 24% of the individuals who experienced inter-unit transfer per month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1154 1887 1421"> <thead> <tr> <th></th> <th><i>Overall compliance rate</i></th> <th></th> </tr> </thead> <tbody> <tr> <td>1.</td> <td><i>Psychiatric course of hospitalization,</i></td> <td>99%</td> </tr> <tr> <td>2.</td> <td><i>Medical course of hospitalization,</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>Current target symptoms,</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Psychiatric risk assessment,</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Current barriers to discharge,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Anticipated benefits of transfer.</i></td> <td>100%</td> </tr> </tbody> </table>		<i>Overall compliance rate</i>		1.	<i>Psychiatric course of hospitalization,</i>	99%	2.	<i>Medical course of hospitalization,</i>	99%	3.	<i>Current target symptoms,</i>	97%	4.	<i>Psychiatric risk assessment,</i>	100%	5.	<i>Current barriers to discharge,</i>	100%	6.	<i>Anticipated benefits of transfer.</i>	100%
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		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: This monitor reviewed the charts of the following six individuals who experienced inter-unit transfers during the review period:</p> <table border="1" data-bbox="991 487 1407 755"> <thead> <tr> <th>Initials</th> <th>Date of transfer</th> </tr> </thead> <tbody> <tr> <td>CRH</td> <td>2/18/10</td> </tr> <tr> <td>CSA</td> <td>4/9/10</td> </tr> <tr> <td>DM</td> <td>4/2/10</td> </tr> <tr> <td>IS</td> <td>2/19/10</td> </tr> <tr> <td>MVV</td> <td>4/29/10</td> </tr> <tr> <td>TNH</td> <td>6/7/10</td> </tr> </tbody> </table> <p>This review found substantial compliance in two charts (DM and IS) and partial compliance in four (CRH, CSA, MVV and TNH). In order to attain substantial compliance with this requirement, the facility needs to continue current efforts to ensure that the assessment delineates current target symptoms and barriers to discharge as well as a specific plan that addresses both.</p> <p>Compliance: Partial, improved compared to the last review</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure correction of the deficiencies listed above. 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). 	Initials	Date of transfer	CRH	2/18/10	CSA	4/9/10	DM	4/2/10	IS	2/19/10	MVV	4/29/10	TNH	6/7/10
Initials	Date of transfer															
CRH	2/18/10															
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IS	2/19/10															
MVV	4/29/10															
TNH	6/7/10															

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2. Psychological Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none">1. Allison Pate, PhD, Senior Supervising Psychologist2. David Haimson, PhD, Chief of Psychology3. Gari-Lyn Richardson, Director of Standards Compliance4. Helga Thordarson, PhD, Senior Supervising Psychologist5. Mark Williams, PhD6. Melanie Byde, PhD, Mall Director7. Steve Burman, By Choice Coordinator8. Susan Velasquez, PhD, PSSC Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none">1. The charts of the following 31 individuals: AB, AF, ALA, CJB, CSA, CV, CWP, DJG, EG, GB, GK, GPR, HJA, JAP, JG, JGC, JJB, JJS, JMM, KA, MB, MO, NJK, PAR, PP, RL, RR, SAV, SB, SM, and TN2. Focused Psychological Assessments completed during this review period3. Integrated Psychological Assessments: Psychology Section completed during this review period4. List of individuals needing cognitive and academic assessments within 30 days of admission5. List of individuals referred for neuropsychological assessments6. List of individuals referred for neuropsychological assessments due to seizure disorders7. List of individuals tested in their primary/preferred language8. List showing senior psychologists' observation of psychological assessments9. Structural/Functional Assessments <p><u>Observed:</u></p> <ol style="list-style-type: none">1. WRPC (Program IV, unit 34) for monthly review of MT

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		<ol style="list-style-type: none"> 2. WRPC (Program IV, unit 43) for monthly review of STJ 3. WRPC (Program VI, unit EB-10) for quarterly review of CCH 4. Mall Group: Creative Art Therapy 5. Mall Group: Cognitive Remediation 6. Mall Group: WRAP 7. Mall Group: Cognitive Remediation Group (RISE) 8. Mall Group: Medication Education 9. Mall Group: Coping Skills 10. Mall Group: Social Skills
D.2.a	<p>Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: PSH has completed all required protocols and manuals to meet this requirement. PSH did not develop any new assessment tools or manuals during this review period</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
D.2.b	<p>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>

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		<p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of all individuals below 23 years of age during this review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 378 1887 638"> <tr> <td data-bbox="991 378 1087 638">1.</td> <td data-bbox="1087 378 1793 638"><i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i></td> <td data-bbox="1793 378 1887 638">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>This monitor reviewed the chart of one individual under 23 years of age (JMM) admitted at PSH during this review period meeting the criteria for the intellectual and academic assessment to be completed within 30 days of admission. The other under-23 individuals admitted during this review period possessed a GED or a high school diploma and did not require the assessments. Assessments for JMM were completed in a timely fashion.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	100%
1.	<i>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals (i.e., 22 years or younger), as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</i>	100%			
D.2.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are	Current findings on previous recommendation:			

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	<p>verifiably competent in the methodology required to conduct the assessment.</p>	<p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: The following table describes PSH's psychology staffing pattern as of June 9, 2010.</p> <table border="1" data-bbox="991 451 1852 604"> <thead> <tr> <th></th> <th>Filled positions</th> <th>Vacant positions</th> </tr> </thead> <tbody> <tr> <td>Unit psychologist</td> <td>65</td> <td>3</td> </tr> <tr> <td>Senior psychologist</td> <td>8</td> <td>0</td> </tr> <tr> <td>Neuropsychologist</td> <td>6</td> <td>0</td> </tr> </tbody> </table> <p>According to the Chief of Psychology, PSH has filled 94% of the allocated psychology staffing. Four psychologists had left the facility since the last review period, and two new psychologists were hired during the same period. The facility is interviewing candidates to fill the vacant positions.</p> <p>Other findings: The following table shows the number of staff involved in performing evaluations, the number of staff meeting the facility's credentialing and privileging requirements, and the number of staff observed and found to be competent:</p> <table border="1" data-bbox="991 1084 1885 1419"> <tbody> <tr> <td>1.a</td> <td><i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i></td> <td>94</td> </tr> <tr> <td>1.b</td> <td><i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i></td> <td>94</td> </tr> <tr> <td>2.a</td> <td><i>Number of psychologists observed while undertaking psychological assessments</i></td> <td>10</td> </tr> <tr> <td>2.b</td> <td><i>Number observed to be verifiably competent in assessment procedures</i></td> <td>10</td> </tr> </tbody> </table>		Filled positions	Vacant positions	Unit psychologist	65	3	Senior psychologist	8	0	Neuropsychologist	6	0	1.a	<i>Number of psychologists who are responsible for performing or reviewing psychological assessments and evaluations</i>	94	1.b	<i>Number of psychologists who meet the hospital's credentialing and privileging requirements</i>	94	2.a	<i>Number of psychologists observed while undertaking psychological assessments</i>	10	2.b	<i>Number observed to be verifiably competent in assessment procedures</i>	10
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		<p>According to the Chief of Psychology, all 94 psychologists at PSH have met the facility's credentialing and privileging criteria.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	<p>Compliance: Substantial.</p>			
D.2.d.i	expressly state the clinical question(s) for the assessment;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Documentation review found that PSH had completed a total of 119 Focused Psychological Assessments during this review period. PSH has established a system of review and corrective feedback on all completed focused psychological assessments.</p> <p>Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 73% of the Focused Psychological Assessments due each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="989 1341 1887 1414"> <tr> <td>3.</td> <td><i>Expressly state the clinical question(s) for the assessment.</i></td> <td>100%</td> </tr> </table>	3.	<i>Expressly state the clinical question(s) for the assessment.</i>	100%
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		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six contained clear and concise statements with a rationale for the referral (AB, HJA, JJB, SAV, SB and SM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 73% of the Focused Psychological Assessments due each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1003 1890 1117"> <tr> <td data-bbox="991 1003 1087 1117">4.</td> <td data-bbox="1087 1003 1793 1117"><i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i></td> <td data-bbox="1793 1003 1890 1117">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested</p>	4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	100%
4.	<i>Include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.</i>	100%			

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		<p>interventions for inclusion in the individual's WRP (AB, HJA, JJB, SAV, SB and SM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.iii	<p>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 73% of the Focused Psychological Assessments due each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 821 1890 935"> <tr> <td>5.</td> <td><i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six indicated if the individual would benefit from individual and/or group therapy (AB, HJA, JJB, SAV, SB and SM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	99%
5.	<i>Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups.</i>	99%			
D.2.d.iv	<p>be based on current, accurate, and complete data;</p>	<p>Current findings on previous recommendation:</p>			

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		<p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 73% of the Focused Psychological Assessments due each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 526 1887 565"> <tr> <td data-bbox="993 526 1087 565">6.</td> <td data-bbox="1087 526 1793 565"><i>Be based on current, accurate, and complete data.</i></td> <td data-bbox="1793 526 1887 565">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six included the identification information, listed the sources of information and documented direct observation information, including the individual's cooperation and motivation during the evaluation (AB, HJA, JJB, SAV, SB and SM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	6.	<i>Be based on current, accurate, and complete data.</i>	100%
6.	<i>Be based on current, accurate, and complete data.</i>	100%			
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;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 73% of the Focused Psychological Assessments due each month for the review period (November 2009-April 2010):</p>			

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		<table border="1" data-bbox="993 228 1887 378"> <tr> <td data-bbox="993 228 1087 378">7.</td> <td data-bbox="1087 228 1793 378"><i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i></td> <td data-bbox="1793 228 1887 378">100%</td> </tr> </table> <p data-bbox="993 418 1902 488">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 532 1902 672">A review of the Focused Psychology Assessments for six individuals found that all six indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support (AB, HJA, JJB, SAV, SB and SM),</p> <p data-bbox="993 716 1457 786">Current recommendation: Continue to monitor this requirement.</p>	7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	100%
7.	<i>Determine whether behavioral supports or interventions (e.g., Behavior Guidelines) are warranted or whether a full Positive Behavior Support plan is required</i>	100%			
D.2.d.vi	include the implications of the findings for interventions;	<p data-bbox="993 829 1577 857">Current findings on previous recommendation:</p> <p data-bbox="993 902 1457 972">Recommendation, December 2009: Continue to monitor this requirement.</p> <p data-bbox="993 1016 1877 1192">Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 73% of the Focused Psychological Assessments due each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 1230 1887 1305"> <tr> <td data-bbox="993 1230 1087 1305">8.</td> <td data-bbox="1087 1230 1793 1305"><i>Include the implications of the findings for interventions</i></td> <td data-bbox="1793 1230 1887 1305">100%</td> </tr> </table> <p data-bbox="993 1349 1902 1419">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	8.	<i>Include the implications of the findings for interventions</i>	100%
8.	<i>Include the implications of the findings for interventions</i>	100%			

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		<p>A review of the Focused Psychology Assessments for six individuals found that all six contained documentation of the implications of the findings for PSR and other interventions (AB, HJA, JJB, SAV, SB and SM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d.vii	<p>identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 73% of the Focused Psychological Assessments due each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 894 1887 1081"> <tr> <td data-bbox="991 894 1087 1081">9.</td> <td data-bbox="1087 894 1793 1081"><i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i></td> <td data-bbox="1793 894 1887 1081">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six contained statements on unresolved issues encompassed by the assessment, avenues to resolve the inconsistencies and a timeline for doing so (AB, HJA, JJB, SAV, SB and SM).</p>	9.	<i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>	99%
9.	<i>Identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues.</i>	99%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.d. viii	<p>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 73% of the Focused Psychological Assessments due each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 711 1890 860"> <tr> <td>10.</td> <td><i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the Focused Psychology Assessments for six individuals found that all six had used assessment tools that were appropriate to address the referral questions and for the individuals assessed in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing (AB, HJA, JJB, SAV, SB and SM).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	99%
10.	<i>Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing</i>	99%			
D.2.e	<p>Each State hospital shall ensure that all psychological assessments of all individuals residing</p>	<p>PSH has completed the review of the psychological assessments of all individuals admitted prior to the Effective Date of the Enhancement Plan</p>			

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	<p>at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</p>	<p>and where indicated, conducted re-assessments.</p> <p>Compliance: Substantial.</p>			
<p>D.2.f</p>	<p>Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:</p>	<p>Compliance: Substantial.</p>			
<p>D.2.f.i</p>	<p>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 99% of the Integrated Assessments: Psychology Section (IAPs) due each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="989 1304 1887 1414"> <tr> <td data-bbox="989 1304 1087 1414">12.</td> <td data-bbox="1087 1304 1793 1414"><i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i></td> <td data-bbox="1793 1304 1887 1414">94%</td> </tr> </table>	12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	94%
12.	<i>Before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed.</i>	94%			

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		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the IAPs for eight individuals found that all eight were conducted in a timely manner (ALA, CV, DJG, GB, JG, JGC, JMM and KA).</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.f.i.1	<p>address the nature of the individual's impairments to inform the psychiatric diagnosis; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 971 1887 1045"> <tr> <td data-bbox="991 971 1087 1045">13.</td> <td data-bbox="1087 971 1793 1045"><i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i></td> <td data-bbox="1793 971 1887 1045">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the IAPs for eight individuals found that all eight had documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis (ALA, CV, DJG, GB, JG, JGC, JMM and KA).</p>	13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	98%
13.	<i>Address the nature of the individual's impairments to inform the psychiatric diagnosis</i>	98%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
D.2.f.i.2	<p>provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) completed each month for the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 711 1887 824"> <tr> <td data-bbox="991 711 1087 824">14.</td> <td data-bbox="1087 711 1793 824"><i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i></td> <td data-bbox="1793 711 1887 824">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the IAPs for eight individuals found that seven provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted to assist the WRPTs in determining the interventions needed for the individual's rehabilitation (CV, DJG, GB, JG, JGC, JMM and KA). The remaining IAP could have provided more focused recommendations with goals and rationale for the recommendations made (ALA).</p> <p>The following is a suggestion for further enhancement of practice during the maintenance phase. When conducting integrated assessments, psychological examiners should try to categorize the individual's maladaptive behaviors, as characterization of the type of aggression in</p>	14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	99%
14.	<i>Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process.</i>	99%			

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		<p>which a patient engages may help the WRPT to enroll the individual to a more focused individual therapies and Mall groups. For example, individuals with anger control difficulties would benefit from cognitive behavior strategies; aggression by individuals diagnosed with borderline personality disorder would benefit from dialectical behavioral therapy; and certain treatment-refractory patients might benefit from medication adjustment. In the absence of such categorization, the WRPT may end up enrolling individuals with all types of aggression in similar programs such as anger management groups.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.2.f.ii	<p>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: See F.2.c</p> <p>Current recommendation: Continue current practice.</p>
D.2.f.iii	<p>additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH assessed its compliance based on an average sample of 100% of the Integrated Assessments: Psychology Section (IAPs) due each month during the</p>

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		<p>review period (November 2009-April 2010). The following table showing the diagnosis and the corresponding compliance rate of assessments that resolved the diagnostic uncertainties is a summary of the facility's data:</p> <table border="1" data-bbox="991 337 1890 532"> <tr> <td>16.</td> <td><i>Differential diagnosis</i></td> <td>100%</td> </tr> <tr> <td>17.</td> <td><i>Rule-out</i></td> <td>100%</td> </tr> <tr> <td>18.</td> <td><i>Deferred</i></td> <td>97%</td> </tr> <tr> <td>19.</td> <td><i>No diagnosis</i></td> <td>100%</td> </tr> <tr> <td>20.</td> <td><i>NOS diagnosis</i></td> <td>97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor reviewed the charts of 12 individuals whose diagnoses needed clarification due to insufficient information to form a firm diagnosis. The review found that all 12 of the Integrated Assessments in the charts had requested and/or conducted additional psychological assessments (AF, CJB, CWP, GB, GK, GPR, JAP, JG, JJS, NJK, PAR and PP).</p> <p>Current recommendation: Continue to monitor this requirement.</p>	16.	<i>Differential diagnosis</i>	100%	17.	<i>Rule-out</i>	100%	18.	<i>Deferred</i>	97%	19.	<i>No diagnosis</i>	100%	20.	<i>NOS diagnosis</i>	97%
16.	<i>Differential diagnosis</i>	100%															
17.	<i>Rule-out</i>	100%															
18.	<i>Deferred</i>	97%															
19.	<i>No diagnosis</i>	100%															
20.	<i>NOS diagnosis</i>	97%															
D.2.g	<p>For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Assessment Monitoring Form, PSH reported the following totals for the review period (November 2009-April 2010):</p>															

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		21.a	<i>Number of individuals who needed assessment during the evaluation period whose primary language was not English</i>	32
		21.b	<i>Of those in 21.a, number of individuals who were assessed in their primary language</i>	13
		22.a	<i>Of those in 21.a, number of individuals who could not be assessed</i>	19
		22.b	<i>Of those in 22.a, number of individuals who had plans developed to meet their assessment needs</i>	19
		23.	<i>Of those in 22.b, number of individuals whose plans for assessment were implemented</i>	19
		<p>A review of the charts of nine individuals found that all nine assessments in the charts were completed in the individual's primary language by bilingual examiners or with the use of interpreters (CSA, CV, EG, GB, MB, MO, RL, RR and TN).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		

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3. Nursing Assessments					
		<p>Methodology:</p> <p><u>Interviewed:</u> Lidia Lau, RN, ACNS</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH's progress report and data 2. PSH's training rosters 3. Admission and integrated assessments and WRPs for the following 40 individuals: AAA, AB, AJB, AL, AS, CHC, CP, CW, DL, EMM, FGC, FL, HAT, JA, JAD, JAG, JAP, JG, JL, KA, LDF, LHH, LJ, LLP, MAA, MDM, MVV, NDR, NJK, PAR, PCJ, PDU, PMC, SCH, SF, SMM, SPE, SRT, STS and TLD 			
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	<p>Compliance: Substantial.</p>			
D.3.a.i	a description of presenting conditions;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 95% mean sample of admissions each month during the review period (November 2009-April 2010):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1.</td> <td style="width: 85%;"><i>A description of presenting conditions</i></td> <td style="width: 10%; text-align: center;">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of</p>	1.	<i>A description of presenting conditions</i>	95%
1.	<i>A description of presenting conditions</i>	95%			

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		<p>at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AAA, AB, AJB, AL, AS, CHC, CP, CW, DL, EMM, FGC, FL, HAT, JA, JAD, JAG, JAP, JG, JL, KA, LDF, LHH, LJ, LLP, MAA, MDM, MVV, NDR, NJK, PAR, PCJ, PDU, PMC, SCH, SF, SMM, SPE, SRT, STS and TLD) found that PSH has maintained the quality of the assessments and has continued to make improvements, especially in the narrative content of the admission assessments. The content of the nursing assessments included specific clinical information gathered from the admission interviews and summarized in the narrative sections addressing the presenting conditions. These sections of the assessments were found to be exceptional. In one nursing assessment (SRT), the information contained in the narrative section was comprehensive but the documentation of the individual's gender (he/she) was inconsistent throughout the section. The efforts that PSH has put into the nursing admission assessment process have produced thorough and comprehensive nursing admission assessments. These findings comport with PSH's data.</p> <p>Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH assessed its compliance based on a 91% mean sample of admissions each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1042 1887 1192"> <tr> <td data-bbox="991 1042 1087 1192">1.</td> <td data-bbox="1087 1042 1793 1192"><i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i></td> <td data-bbox="1793 1042 1887 1192">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AAA, AB, AJB, AL, AS, CHC, CP, CW, DL, EMM, FGC, FL, HAT, JA, JAD, JAG,</p>	1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	95%
1.	<i>The present status of the Integrated Assessment: Nursing Section is complete, or there is documentation that the individual is non-adherent with the interview.</i>	95%			

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		<p>JAP, JG, JL, KA, LDF, LHH, LJ, LLP, MAA, MDM, MVV, NDR, NJK, PAR, PCJ, PDU, PMC, SCH, SF, SMM, SPE, SRT, STS and TLD) found that PSH has also maintained significant improvement in the quality and content of the Integrated Nursing Assessments since the last review. The information contained in the Integrated Assessments included updated information since the individual was admitted rather than just repeating information that was contained in the Nursing Assessment. Additionally, changes in the individual's affect and response from the initial assessments were frequently discussed in the integrated assessments. The training that PSH has implemented addressing nursing admission/integrated assessments has resulted in exceptional clinical nursing assessments/integrated assessments. These findings comport with PSH's data.</p> <p>Current recommendation: Continue current practice.</p>			
D.3.a.ii	current prescribed medications;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="991 896 1887 1193"> <tr> <td data-bbox="991 896 1087 1193">2.</td> <td data-bbox="1087 896 1793 1193"><i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i></td> <td data-bbox="1793 896 1887 1193">97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	97%
2.	<i>On the Admission Nursing Assessment, all currently prescribed medications are documented to include the last time taken, dose, side effects if any, the individual's understanding of the medication and reasons for treatment OR there is documentation that medication records are not available and the individual is unable to provide any information about past medication history.</i>	97%			

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		<p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 266 1892 454"> <tr> <td data-bbox="993 266 1087 454">2.</td> <td data-bbox="1087 266 1793 454"><i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i></td> <td data-bbox="1793 266 1892 454">92%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	92%			
2.	<i>On the Integrated Nursing Assessment, all sections of the medication management section are complete, or there is documentation that the individual is non-adherent with the interview, or the "no medication" box is checked.</i>	92%						
D.3.a.iii	vital signs;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 677 1892 716"> <tr> <td data-bbox="993 677 1087 716">3.</td> <td data-bbox="1087 677 1793 716"><i>Vital signs</i></td> <td data-bbox="1793 677 1892 716">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1" data-bbox="993 938 1892 977"> <tr> <td data-bbox="993 938 1087 977">3.</td> <td data-bbox="1087 938 1793 977"><i>Vital signs</i></td> <td data-bbox="1793 938 1892 977">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	3.	<i>Vital signs</i>	100%	3.	<i>Vital signs</i>	98%
3.	<i>Vital signs</i>	100%						
3.	<i>Vital signs</i>	98%						
D.3.a.iv	allergies;	<p><u>Admission Assessments</u></p> <table border="1" data-bbox="993 1200 1892 1239"> <tr> <td data-bbox="993 1200 1087 1239">4.</td> <td data-bbox="1087 1200 1793 1239"><i>Allergies</i></td> <td data-bbox="1793 1200 1892 1239">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	4.	<i>Allergies</i>	99%			
4.	<i>Allergies</i>	99%						

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

Section D: Integrated Assessments

		<table border="1"> <tr> <td></td> <td><i>complete, or the "no problems noted" box is checked.</i></td> <td></td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>		<i>complete, or the "no problems noted" box is checked.</i>				
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D.3.a.vii	activities of daily living;	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>7.</td> <td><i>Activities of daily living</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	7.	<i>Activities of daily living</i>	99%	7.	<i>Activities of daily living</i>	99%
7.	<i>Activities of daily living</i>	99%						
7.	<i>Activities of daily living</i>	99%						
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>8.</td> <td><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>8.</td> <td><i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i></td> <td>98%</td> </tr> </table>	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	98%	8.	<i>The Risks/Alerts Requiring immediate nursing interventions section is completed or the "none known" box is checked.</i>	98%
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		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>						
D.3.a.ix	<p>conditions needing immediate nursing interventions.</p>	<p><u>Admission Assessments</u></p> <table border="1"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p><u>Integrated Assessments</u></p> <table border="1"> <tr> <td>9.</td> <td><i>Conditions needing immediate nursing interventions</i></td> <td>99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	9.	<i>Conditions needing immediate nursing interventions</i>	95%	9.	<i>Conditions needing immediate nursing interventions</i>	99%
9.	<i>Conditions needing immediate nursing interventions</i>	95%						
9.	<i>Conditions needing immediate nursing interventions</i>	99%						
D.3.b	<p>Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: PSH's Central Nursing Services policy and procedures demonstrate that the facility is consistently using the Wellness and Recovery model for nursing.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>						

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D.3.c	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 Patton State Hospital shall have graduated from an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: PSH's training rosters indicated that 76 RNs received and passed the Nursing Assessment training during the current review period. In addition, all nurses at PSH were currently licensed.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	<p>Compliance: Substantial.</p>			
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Nursing Admission Assessment Monitoring Audit, PSH assessed its compliance based on a 95% mean sample of admissions each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1304 1890 1382"> <tr> <td data-bbox="991 1304 1087 1382">10.</td> <td data-bbox="1087 1304 1793 1382"><i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i></td> <td data-bbox="1793 1304 1890 1382">99%</td> </tr> </table>	10.	<i>Initial nursing assessments are completed within 24 hours of the individual's admission.</i>	99%
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		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Nursing Admission Assessments for 40 individuals (AAA, AB, AJB, AL, AS, CHC, CP, CW, DL, EMM, FGC, FL, HAT, JA, JAD, JAG, JAP, JG, JL, KA, LDF, LHH, LJ, LLP, MAA, MDM, MVV, NDR, NJK, PAR, PCJ, PDU, PMC, SCH, SF, SMM, SPE, SRT, STS and TLD) found that all were timely completed.</p> <p>Current recommendation: Continue current practice.</p>			
D.3.d.ii	<p>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Nursing Integrated Assessment Monitoring Audit, PSH assessed its compliance based on a 91% mean sample of admissions each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1008 1887 1156"> <tr> <td data-bbox="991 1008 1087 1156">10.</td> <td data-bbox="1087 1008 1793 1156"><i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i></td> <td data-bbox="1793 1008 1887 1156">92%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of Integrated Nursing Assessments for 40 individuals (AAA, AB, AJB, AL, AS, CHC, CP, CW, DL, EMM, FGC, FL, HAT, JA, JAD, JAG, JAP, JG, JL, KA, LDF, LHH, LJ, LLP, MAA, MDM, MVV, NDR, NJK, PAR,</p>	10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	92%
10.	<i>Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission.</i>	92%			

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		<p>PCJ, PDU, PMC, SCH, SF, SMM, SPE, SRT, STS and TLD) found that 36 were timely completed; three were completed prior to the 4-5 day requirement (JA, PAR and TLD); and one was completed after the required timeframe (AL).</p> <p>Current recommendation: Substantial.</p>									
D.3.d.iii	<p>Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on a mean sample of 20% of WRPCs observed each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 857 1915 1011"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td><i>Registered Nurse attendance at WRPC</i></td> <td>96%</td> <td>98%</td> </tr> <tr> <td><i>Psychiatric Technician attendance at WRPC</i></td> <td>85%</td> <td>96%</td> </tr> </tbody> </table> <p>A review of the charts of 40 individuals (AAA, AB, AJB, AL, AS, CHC, CP, CW, DL, EMM, FGC, FL, HAT, JA, JAD, JAG, JAP, JG, JL, KA, LDF, LHH, LJ, LLP, MAA, MDM, MVV, NDR, NJK, PAR, PCJ, PDU, PMC, SCH, SF, SMM, SPE, SRT, STS and TLD) found that 39 had an RN and 35 had a PT in attendance at the WRPC.</p> <p>Other findings: The signature page of the WRP for 15 individuals did not include some or all of the signatures of the staff members who were indicated to be present at the WRPC (AS, CHC, CP, EMM, FGC, FL, JAD, JG, JL, LDF,</p>		Previous period	Current period	<i>Registered Nurse attendance at WRPC</i>	96%	98%	<i>Psychiatric Technician attendance at WRPC</i>	85%	96%
	Previous period	Current period									
<i>Registered Nurse attendance at WRPC</i>	96%	98%									
<i>Psychiatric Technician attendance at WRPC</i>	85%	96%									

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		<p>LHH, MAA, MVV, PCJ and TLD).</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Ensure that staff members who attend the WRPCs sign the WRP signature page.2. Continue to monitor this requirement.
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4. Rehabilitation Therapy Assessments		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Chris Keierleber, Senior Rehabilitation Therapist 2. Greg Siples, Director of Rehabilitation Therapy Services 3. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist 4. Michael Gomes, Senior Rehabilitation Therapist 5. Renata Geyer, Senior Rehabilitation Therapist 6. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 7. Stan Hydinger, Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. List of individuals who had IA-RTS assessments from November 2009-April 2010 2. Records of the following 15 individuals who had IA-RTS assessments from November 2009-April 2010: CMM, CR, DH, DPP, EB, FW, JAJ, JAR, JG, KDP, LM, MAW, MP, NJG and NNS 3. List of individuals who had Occupational Therapy assessments from November 2009-April 2010 4. Records of the following seven individuals who had Occupational Therapy assessments from November 2009-April 2010: AO, CM, FSL, GT, RAJ, TH and TN 5. List of individuals who had Physical Therapy assessments from November 2009-April 2010 6. Records of the following five individuals who had Physical Therapy assessments from November 2009-April 2010: MAH, RA-1, RA-2, VT and WPW 7. List of individuals who had Speech Therapy assessments from November 2009-April 2010 8. Records of the following six individuals who had Speech Therapy assessments from November 2009-April 2010: AG, JPK, LW, MPC, RDB and TS

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		<p>9. List of individuals who had Vocational Rehabilitation assessments from November 2009-April 2010</p> <p>10. Records of the following seven individuals who had Vocational Rehabilitation assessments from November 2009-April 2010: AH, BYB, GPP, JAM, JE, MSK and WKP</p> <p>11. List of individuals who had CIPRTA assessments from November 2009-April 2010</p> <p>12. Records of the following four individuals who had CIPRTA assessments from November 2009-April 2010: DB, DM, PSC and SD</p> <p><u>Observed:</u> IA-RTS Clinic</p>
D.4.a	<p>Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Current assessment protocols appear to meet generally accepted standards of care for satisfying necessary components of comprehensive rehabilitation therapy assessments. Assessment tools should be revised and updated based on changes in systemic needs and evolving standards of practice.</p> <p>An observation of the IA-RTS clinic found that the admission therapy team was conducting individualized activity-based assessments and interviews in a group format, which is consistent with assessment protocol. All individuals were engaged in the assessment activities and the clinicians observed appeared to have an excellent rapport with individuals during the assessment process.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>			
D.4.b	<p>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period November 2009-April 2010 (total of 525):</p> <table border="1" data-bbox="991 857 1887 1081"> <tr> <td data-bbox="991 857 1087 1081">1.</td> <td data-bbox="1087 857 1793 1081"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i></td> <td data-bbox="1793 857 1887 1081">99%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i>	99%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within five calendar days of the individual's admission and filed in the medical record];</i>	99%			

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		<p>sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 32):</p> <table border="1" data-bbox="991 302 1887 490"> <tr> <td data-bbox="991 302 1087 490">1.</td> <td data-bbox="1087 302 1793 490"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 302 1887 490">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Occupational Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 59):</p> <table border="1" data-bbox="991 971 1887 1159"> <tr> <td data-bbox="991 971 1087 1159">1.</td> <td data-bbox="1087 971 1793 1159"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 971 1887 1159">99%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with timeliness found four records in compliance (MAH, RA-1, RA-2 and WPW) and one record not in</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	99%
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		<p>compliance (VT).</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 32):</p> <table border="1" data-bbox="991 451 1890 638"> <tr> <td data-bbox="991 451 1087 638">1.</td> <td data-bbox="1087 451 1793 638"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 451 1890 638">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2009-April 2010 (total of 81):</p> <table border="1" data-bbox="991 1154 1890 1341"> <tr> <td data-bbox="991 1154 1087 1341">1.</td> <td data-bbox="1087 1154 1793 1341"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 1154 1890 1341">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%						
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 30 days of referral and filed in the medical record];</i>	100%						

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		<p>least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Vocational Rehabilitation Focused Assessments with timeliness found all records in compliance.</p> <p>Using the DMH Comprehensive Integrated Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with timeliness based on an average sample of 100% of CIPRTA assessments due each month for the review period November 2009-April 2010 (total of 12):</p> <table border="1" data-bbox="991 636 1887 821"> <tr> <td data-bbox="991 636 1087 821">1.</td> <td data-bbox="1087 636 1793 821"><i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i></td> <td data-bbox="1793 636 1887 821">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with timeliness found all records in compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%
1.	<i>Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care, [was completed within 14 days of referral and filed in the medical record];</i>	100%			
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	Current findings on previous recommendation:			

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		<p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period November 2009-April 2010 (total of 525):</p> <table border="1" data-bbox="991 561 1887 638"> <tr> <td data-bbox="991 561 1087 638">2.</td> <td data-bbox="1087 561 1793 638"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 561 1887 638">98%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 32):</p> <table border="1" data-bbox="991 1154 1887 1230"> <tr> <td data-bbox="991 1154 1087 1230">2.</td> <td data-bbox="1087 1154 1793 1230"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 1154 1887 1230">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	98%	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%
2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	98%						
2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%						

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		<p>Occupational Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 59):</p> <table border="1" data-bbox="991 487 1890 565"> <tr> <td data-bbox="991 487 1087 565">2.</td> <td data-bbox="1087 487 1793 565"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 487 1890 565">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 32):</p> <table border="1" data-bbox="991 1044 1890 1122"> <tr> <td data-bbox="991 1044 1087 1122">2.</td> <td data-bbox="1087 1044 1793 1122"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 1044 1890 1122">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%
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2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%						

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		<p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2009-April 2010 (total of 81):</p> <table border="1" data-bbox="991 414 1887 490"> <tr> <td data-bbox="991 414 1087 490">2.</td> <td data-bbox="1087 414 1793 490"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 414 1887 490">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.i criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.i criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period November 2009-April 2010 (total of 12):</p> <table border="1" data-bbox="991 1008 1887 1084"> <tr> <td data-bbox="991 1008 1087 1084">2.</td> <td data-bbox="1087 1008 1793 1084"><i>Is accurate and comprehensive as to the individual's functional abilities;</i></td> <td data-bbox="1793 1008 1887 1084">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.i criteria found all records in substantial compliance.</p>	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%	2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%
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2.	<i>Is accurate and comprehensive as to the individual's functional abilities;</i>	100%						

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period November 2009-April 2010 (total of 525):</p> <table border="1" data-bbox="991 857 1887 1010"> <tr> <td data-bbox="991 857 1087 933">3.</td> <td data-bbox="1087 857 1793 933"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 857 1887 933">99%</td> </tr> <tr> <td data-bbox="991 933 1087 1010">4.</td> <td data-bbox="1087 933 1793 1010"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 933 1887 1010">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments</p>	3.	<i>Identifies the individual's current functional status, and</i>	99%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
3.	<i>Identifies the individual's current functional status, and</i>	99%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%						

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		<p>due each month for the review period November 2009-April 2010 (total of 32):</p> <table border="1" data-bbox="991 302 1887 453"> <tr> <td data-bbox="991 302 1087 376">3.</td> <td data-bbox="1087 302 1793 376"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 302 1887 376">100%</td> </tr> <tr> <td data-bbox="991 376 1087 453">4.</td> <td data-bbox="1087 376 1793 453"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 376 1887 453">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of seven individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 59):</p> <table border="1" data-bbox="991 933 1887 1084"> <tr> <td data-bbox="991 933 1087 1008">3.</td> <td data-bbox="1087 933 1793 1008"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 933 1887 1008">100%</td> </tr> <tr> <td data-bbox="991 1008 1087 1084">4.</td> <td data-bbox="1087 1008 1793 1084"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 1008 1887 1084">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool,</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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		<p>PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 32):</p> <table border="1" data-bbox="991 337 1887 490"> <tr> <td data-bbox="991 337 1087 412">3.</td> <td data-bbox="1087 337 1793 412"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 337 1887 412">100%</td> </tr> <tr> <td data-bbox="991 412 1087 490">4.</td> <td data-bbox="1087 412 1793 490"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 412 1887 490">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2009-April 2010 (total of 81):</p> <table border="1" data-bbox="991 1008 1887 1161"> <tr> <td data-bbox="991 1008 1087 1083">3.</td> <td data-bbox="1087 1008 1793 1083"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 1008 1887 1083">100%</td> </tr> <tr> <td data-bbox="991 1083 1087 1161">4.</td> <td data-bbox="1087 1083 1793 1161"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 1083 1887 1161">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of seven individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.ii criteria found all records in substantial compliance.</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
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		<p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.ii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period November 2009-April 2010 (total of 12):</p> <table border="1" data-bbox="993 451 1887 602"> <tr> <td data-bbox="993 451 1087 526">3.</td> <td data-bbox="1087 451 1793 526"><i>Identifies the individual's current functional status, and</i></td> <td data-bbox="1793 451 1887 526">100%</td> </tr> <tr> <td data-bbox="993 526 1087 602">4.</td> <td data-bbox="1087 526 1793 602"><i>The skills and supports needed to facilitate transfer to the next level of care;</i></td> <td data-bbox="1793 526 1887 602">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.ii criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Identifies the individual's current functional status, and</i>	100%	4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%
3.	<i>Identifies the individual's current functional status, and</i>	100%						
4.	<i>The skills and supports needed to facilitate transfer to the next level of care;</i>	100%						
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Integrated Assessment Rehabilitation Therapy Section Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based</p>						

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		<p>on an average sample of 100% of Integrated Rehabilitation Therapy Assessments due each month for the review period November 2009-April 2010 (total of 525):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of 15 individuals to assess compliance of IA-RTS Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Occupational Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Occupational Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 32):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of seven individuals to assess compliance of Occupational Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Physical Therapy Focused Assessment Monitoring Tool,</p>	5.	<i>Identifies the individual's life goals,</i>	98%	6.	<i>Strengths, and</i>	99%	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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6.	<i>Strengths, and</i>	100%																		
7.	<i>Motivation for engaging in wellness activities.</i>	100%																		

Section D: Integrated Assessments

		<p>PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Physical Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 59):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of five individuals to assess compliance of Physical Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Speech Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of Speech Therapy Focused Assessments due each month for the review period November 2009-April 2010 (total of 32):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of six individuals to assess compliance of Speech Therapy Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Vocational Rehabilitation Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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		<p>average sample of 100% of Vocational Rehabilitation Focused Assessments due each month for the review period November 2009-April 2010 (total of 81):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of seven individuals to assess compliance of Vocational Rehabilitation Focused Assessments with D.4.b.iii criteria found all records in substantial compliance.</p> <p>Using the DMH Comprehensive Physical Rehabilitation Therapy Focused Assessment Monitoring Tool, PSH assessed its compliance with D.4.b.iii criteria based on an average sample of 100% of CIPRTA assessments due each month for the review period November 2009-April 2010 (total of 12):</p> <table border="1"> <tr> <td>5.</td> <td><i>Identifies the individual's life goals,</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Strengths, and</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Motivation for engaging in wellness activities.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all three items.</p> <p>A review of the records of four individuals to assess compliance of CIPRTA assessments with D.4.b.iii criteria found all records in substantial compliance.</p>	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%	5.	<i>Identifies the individual's life goals,</i>	100%	6.	<i>Strengths, and</i>	100%	7.	<i>Motivation for engaging in wellness activities.</i>	100%
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The facility reported that during the review period, one out of one physical therapist, one out of one physical therapy assistant, and seven out of seven Rehabilitation Therapists were trained to competency on the screening tools and/or assessments for which they are responsible. Inter-rater agreement is reported to range from 92-100% for Integrated and Focused Assessments.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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 D.4.b and sub-cells above.	<p>All conversion assessments were completed as of the June 2009 tour.</p> <p>Compliance: Substantial.</p>

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5. Nutrition Assessments		
D.5	<p>Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brian Starck-Riley, Assistant Director of Nutrition Services 2. Diana Tran, Assistant Director of Nutrition Services 3. Jeanie Kim, Assistant Director of Nutrition Services 4. Tai Kim, Director of Nutrition Services 5. Vivian Collins, Acting Assistant Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Nutrition Care Monitoring audit data for November 2009-April 2010 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from November 2009-April 2010 for each assessment type 3. Record of the following individual with type D.5.a assessment from November 2009-April 2010: JLB 4. Records of the following seven individuals with type D.5.d assessments from November 2009-April 2010: CRH, CSA, DDR, DEB, JCS, JM and TE 5. Records of the following seven individuals with type D.5.e assessments from November 2009-April 2010: BLM, CA, CC, JV, MR, RJB and RM 6. Records of the following six individuals with type D.5.f assessments from November 2009-April 2010: CG, GPR, JSC, MG, SC and TG 7. Records of the following nine individuals with type D.5.g assessments from November 2009-April 2010: ADH, AR, CGT, DGG, EMM, HC, LTH, SS and SVE 8. Records of the following nine individuals with type D.5.i assessments from November 2009-April 2010: CES, CK, DB, JDM, JRH, LAG, MEJ, MH and TS 9. Records of the following six individuals with type D.5.j.i assessments from November 2009-April 2010: AP, EDH, GF, JPD, PS and RJ

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		<p>10. Records of the following seven individuals with type D.5.j.ii assessments from November 2009-April 2010: GFW, GNF, NP, RA, TO, VD and WDW</p>																																	
<p>D.5.a</p>	<p>For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>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 November 2009-April 2010 (total of one):</p> <table border="1" data-bbox="991 748 1887 1427"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>100%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	100%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	100%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%	9.	<i>Progress is monitored, measured, and evaluated</i>	100%	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%
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		<table border="1"> <tr> <td data-bbox="989 190 1087 266">12.</td> <td data-bbox="1087 190 1793 266"><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td data-bbox="1793 190 1894 266">100%</td> </tr> <tr> <td data-bbox="989 266 1087 342">13.</td> <td data-bbox="1087 266 1793 342"><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td data-bbox="1793 266 1894 342">100%</td> </tr> <tr> <td data-bbox="989 342 1087 418">14.</td> <td data-bbox="1087 342 1793 418"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1793 342 1894 418">100%</td> </tr> <tr> <td data-bbox="989 418 1087 459">15.</td> <td data-bbox="1087 418 1793 459"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1793 418 1894 459">100%</td> </tr> <tr> <td data-bbox="989 459 1087 500">16.</td> <td data-bbox="1087 459 1793 500"><i>Assessment is concise</i></td> <td data-bbox="1793 459 1894 500">100%</td> </tr> <tr> <td data-bbox="989 500 1087 540">17.</td> <td data-bbox="1087 500 1793 540"><i>Assessment is legible</i></td> <td data-bbox="1793 500 1894 540">100%</td> </tr> <tr> <td data-bbox="989 540 1087 581">18.</td> <td data-bbox="1087 540 1793 581"><i>Each page of the assessment is signed</i></td> <td data-bbox="1793 540 1894 581">100%</td> </tr> </table> <p data-bbox="989 613 1894 719">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p data-bbox="989 760 1894 833">A review of the record of one individual to assess compliance with Nutrition type D.5.d criteria found the record in substantial compliance.</p> <p data-bbox="989 873 1140 938">Compliance: Substantial.</p> <p data-bbox="989 979 1455 1052">Current recommendation: Continue to monitor this requirement.</p>	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	100%	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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18.	<i>Each page of the assessment is signed</i>	100%																					
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.																					

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<p>D.5.d</p>	<p>For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>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 November 2009-April 2010 (total of 60):</p> <table border="1" data-bbox="991 597 1885 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>93%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>97%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>96%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>98%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>98%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>97%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>98%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	93%	2.	<i>All required subjective concerns are addressed</i>	98%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	97%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	98%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	96%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	98%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	98%	11.	<i>Recommendations are appropriate and complete</i>	97%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	98%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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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.	<p data-bbox="995 945 1583 977">Current findings on previous recommendation:</p> <p data-bbox="995 1019 1436 1088">Recommendation, December 2009: Continue current practice.</p> <p data-bbox="995 1130 1898 1308">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 November 2009-April 2010 (total of 24):</p> <table border="1" data-bbox="995 1351 1898 1416"> <tr> <td data-bbox="995 1351 1087 1390">1.</td> <td data-bbox="1087 1351 1793 1390"><i>Assessment is completed on time per policy</i></td> <td data-bbox="1793 1351 1898 1390">88%</td> </tr> <tr> <td data-bbox="995 1390 1087 1416">2.</td> <td data-bbox="1087 1390 1793 1416"><i>All required subjective concerns are addressed</i></td> <td data-bbox="1793 1390 1898 1416">96%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	88%	2.	<i>All required subjective concerns are addressed</i>	96%									
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		<p>sample size and due to a systemic issue with not receiving consistent notification from nursing for new admissions with therapeutic diet orders for medical reasons.</p> <p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.e criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																		
D.5.f	<p>For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>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 due each month for the review period November 2009-April 2010 (total of 39):</p> <table border="1" data-bbox="989 1079 1890 1416"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>95%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>97%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>92%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>97%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated,</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	95%	2.	<i>All required subjective concerns are addressed</i>	97%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	92%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	97%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated,</i>	100%
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			<i>prioritized and validated</i>	
		7.	<i>Nutrition education is documented</i>	100%
		8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
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		18.	<i>Each page of the assessment is signed</i>	95%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p>A review of the records of six individuals to assess compliance with Nutrition type D.5.f criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		

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D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 16% of Nutrition Type D.5.g assessments due each month for the review period November 2009-April 2010 (total of 65 out of 401):</p> <table border="1" data-bbox="991 597 1885 1424"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>97%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>98%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>97%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>98%</td> </tr> <tr> <td>9.</td> <td><i>Progress is monitored, measured, and evaluated</i></td> <td>N/A</td> </tr> <tr> <td>10.</td> <td><i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i></td> <td>100%</td> </tr> <tr> <td>11.</td> <td><i>Recommendations are appropriate and complete</i></td> <td>100%</td> </tr> <tr> <td>12.</td> <td><i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i></td> <td>100%</td> </tr> <tr> <td>13.</td> <td><i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	97%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	98%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	97%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	100%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	98%	7.	<i>Nutrition education is documented</i>	98%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	98%	9.	<i>Progress is monitored, measured, and evaluated</i>	N/A	10.	<i>Nutrition goals are individualized, relate to the nutrition diagnosis, and are realistic and measurable</i>	100%	11.	<i>Recommendations are appropriate and complete</i>	100%	12.	<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	100%	13.	<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
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Section D: Integrated Assessments

		<table border="1" data-bbox="991 191 1890 422"> <tr> <td data-bbox="991 191 1087 267">14.</td> <td data-bbox="1087 191 1795 267"><i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i></td> <td data-bbox="1795 191 1890 267">N/A</td> </tr> <tr> <td data-bbox="991 267 1087 308">15.</td> <td data-bbox="1087 267 1795 308"><i>Assessment utilizes approved abbreviations</i></td> <td data-bbox="1795 267 1890 308">100%</td> </tr> <tr> <td data-bbox="991 308 1087 349">16.</td> <td data-bbox="1087 308 1795 349"><i>Assessment is concise</i></td> <td data-bbox="1795 308 1890 349">100%</td> </tr> <tr> <td data-bbox="991 349 1087 389">17.</td> <td data-bbox="1087 349 1795 389"><i>Assessment is legible</i></td> <td data-bbox="1795 349 1890 389">100%</td> </tr> <tr> <td data-bbox="991 389 1087 422">18.</td> <td data-bbox="1087 389 1795 422"><i>Each page of the assessment is signed</i></td> <td data-bbox="1795 389 1890 422">100%</td> </tr> </table> <p data-bbox="991 462 1890 568">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p data-bbox="991 609 1890 682">A review of the records of nine individuals to assess compliance with Nutrition type D.5.g criteria found all records in substantial compliance.</p> <p data-bbox="991 722 1144 787">Compliance: Substantial.</p> <p data-bbox="991 828 1459 901">Current recommendation: Continue to monitor this requirement.</p>	14.	<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A	15.	<i>Assessment utilizes approved abbreviations</i>	100%	16.	<i>Assessment is concise</i>	100%	17.	<i>Assessment is legible</i>	100%	18.	<i>Each page of the assessment is signed</i>	100%
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18.	<i>Each page of the assessment is signed</i>	100%															
D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	<p data-bbox="991 950 1585 982">Current findings on previous recommendation:</p> <p data-bbox="991 1023 1438 1088">Recommendation, December 2009: Continue current practice.</p> <p data-bbox="991 1128 1890 1388">Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 19% of Nutrition assessments (all types) due each month of the review period November 2009-April 2010 (502 out of 2602). The facility reports that a weighted mean of 98% of Nutrition admission assessments had evidence of a correctly assigned NST level.</p>															

Section D: Integrated Assessments

		<p>A review of the records of 52 individuals found that all had evidence of a correctly assigned Nutritional Status Type and were in compliance with this requirement.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
D.5.i	<p>The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-up as needed.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 14% of Nutrition Type D.5.i assessments due each month for the review period November 2009-April 2010 (total of 185 out of 1276):</p> <table border="1" data-bbox="991 971 1887 1421"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>50%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>92%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>95%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>98%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	50%	2.	<i>All required subjective concerns are addressed</i>	99%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	92%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	95%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	99%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	98%	7.	<i>Nutrition education is documented</i>	98%	8.	<i>Response to MNT is specific to the intervention</i>	100%
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Section D: Integrated Assessments

			<i>provided, adherence potential indicated, and barriers identified</i>	
	9.		<i>Progress is monitored, measured, and evaluated</i>	99%
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	11.		<i>Recommendations are appropriate and complete</i>	100%
	12.		<i>NST is correctly assigned to reflect acuity level and date of next review. Include NST in comment</i>	96%
	13.		<i>Food/fluid consistency is addressed when actual/potential aspiration/dysphagia is present</i>	100%
	14.		<i>Transition to oral feeding regimen is addressed for enteral/parenteral nutrition support</i>	N/A
	15.		<i>Assessment utilizes approved abbreviations</i>	100%
	16.		<i>Assessment is concise</i>	100%
	17.		<i>Assessment is legible</i>	100%
	18.		<i>Each page of the assessment is signed</i>	100%
	<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period except items 1 and 3, for which the compliance rates improved as follows:</p>			
			Previous period	Current period
	Mean compliance rate			
	1.		34%	50%
	3.		86%	92%
	<p>The facility attributed less than substantial compliance with item 1 to RD vacancies, high caseload numbers and the prioritization of higher-acuity assessments and referrals.</p>			

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		<p>A review of the records of nine individuals to assess compliance with Nutrition type D.5.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 17% of Nutrition Type D.5.j.i assessments due each month for the review period November 2009-April 2010 (total of 52 out of 307):</p> <table border="1" data-bbox="991 933 1890 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>88%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>94%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>96%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>94%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i></td> <td>96%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	100%	2.	<i>All required subjective concerns are addressed</i>	98%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	88%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	94%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	98%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	96%	7.	<i>Nutrition education is documented</i>	94%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers</i>	96%
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Section D: Integrated Assessments

			<i>identified</i>													
		9.	<i>Progress is monitored, measured, and evaluated</i>	100%												
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		<p>The facility attributed less than substantial compliance with item 3 to a small sample size due to this item being applicable to a small number of referrals in records reviewed.</p>														
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Section D: Integrated Assessments

		<p>Nutrition type D.5.j.i criteria found all records in substantial compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>																								
D.5.j.ii	Every individual will be assessed annually.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 16% of Nutrition Type D.5.j.ii assessments due each month for the review period November 2009-April 2010 (total of 78 out of 494):</p> <table border="1" data-bbox="991 894 1890 1422"> <tr> <td>1.</td> <td><i>Assessment is completed on time per policy</i></td> <td>58%</td> </tr> <tr> <td>2.</td> <td><i>All required subjective concerns are addressed</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All pertinent objective nutrition information is accurately addressed</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Estimated daily needs for nutrients specified are appropriate</i></td> <td>96%</td> </tr> <tr> <td>5.</td> <td><i>Assessment utilizes findings from subjective and objective data</i></td> <td>98%</td> </tr> <tr> <td>6.</td> <td><i>Nutrition diagnosis is correctly formulated, prioritized and validated</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>Nutrition education is documented</i></td> <td>98%</td> </tr> <tr> <td>8.</td> <td><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i></td> <td>100%</td> </tr> </table>	1.	<i>Assessment is completed on time per policy</i>	58%	2.	<i>All required subjective concerns are addressed</i>	100%	3.	<i>All pertinent objective nutrition information is accurately addressed</i>	100%	4.	<i>Estimated daily needs for nutrients specified are appropriate</i>	96%	5.	<i>Assessment utilizes findings from subjective and objective data</i>	98%	6.	<i>Nutrition diagnosis is correctly formulated, prioritized and validated</i>	100%	7.	<i>Nutrition education is documented</i>	98%	8.	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified</i>	100%
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	9.	<i>Progress is monitored, measured, and evaluated</i>	100%													
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		Previous period	Current period													
	Mean compliance rate															
	1.	43%	58%													
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	<p>The facility attributed less than substantial compliance with item 1 to RD vacancies, high caseload numbers, and the prioritization of higher-acuity assessments and referrals.</p>															
	<p>A review of the records of seven individuals to assess compliance with Nutrition type D.5.j.ii criteria found all records in substantial compliance.</p>															

Section D: Integrated Assessments

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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Section D: Integrated Assessments

6. Social History Assessments											
	<p>Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Hope Marriott, LCSW, Assistant to the Clinical Administrator 2. Lisa Hilder, LCSW, Supervisor Social Worker 3. Rachel Strydom, LCSW, Supervising Social Worker 4. Tiffany Rector, JD, LCSW (A), Supervising Social Worker and Section Leader 5. Veronica Kaufman, LCSW, Chief of Social Work Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The chart of the following nine individuals: ALB, CB, CC, JAR, NB, RUS, SL, VRB and YJ 2. DMH Integrated Assessments: Social Work Section 3. DMH 30-Day Psychosocial Assessments 4. PSH Progress Report Data 5. Family Education Assessments 									
D.6.a	<p>Is, to the extent reasonably possible, accurate, current and comprehensive;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 96% of the Integrated Assessments: Social Work Sections due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 1304 1892 1416"> <tbody> <tr> <td>1.</td> <td><i>Is, to the extent reasonably possible, accurate</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Current, and</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Comprehensive: All sections are completed with at</i></td> <td>100%</td> </tr> </tbody> </table>	1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at</i>	100%
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3.	<i>Comprehensive: All sections are completed with at</i>	100%									

Section D: Integrated Assessments

		<table border="1" data-bbox="993 191 1902 305"> <tr> <td data-bbox="993 191 1094 305"></td> <td data-bbox="1094 191 1797 305"><i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1797 191 1902 305"></td> </tr> </table> <p data-bbox="993 349 1902 418">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 459 1902 565">A review of the records of seven individuals to evaluate the Integrated Assessments: Social Work Sections found that all seven assessments were current and comprehensive (ALB, JAR, NB, RUS, SL, VRB and YJ).</p> <p data-bbox="993 605 1902 751">Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 30% of the 30-Day Psychosocial Assessments due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 784 1902 1011"> <tr> <td data-bbox="993 784 1094 824">1.</td> <td data-bbox="1094 784 1797 824"><i>Is, to the extent reasonably possible, accurate</i></td> <td data-bbox="1797 784 1902 824">100%</td> </tr> <tr> <td data-bbox="993 824 1094 865">2.</td> <td data-bbox="1094 824 1797 865"><i>Current, and</i></td> <td data-bbox="1797 824 1902 865">100%</td> </tr> <tr> <td data-bbox="993 865 1094 1011">3.</td> <td data-bbox="1094 865 1797 1011"><i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i></td> <td data-bbox="1797 865 1902 1011">100%</td> </tr> </table> <p data-bbox="993 1060 1902 1130">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="993 1170 1902 1308">A review of the records of nine individuals to evaluate the 30-Day Psychosocial Assessments found that eight assessments were timely and comprehensive (ALB, CB, JAR, NB, RUS, SL, VRB and YJ) and one was untimely and/or was not comprehensive (CC).</p> <p data-bbox="993 1349 1902 1417">Compliance: Substantial.</p>		<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>		1.	<i>Is, to the extent reasonably possible, accurate</i>	100%	2.	<i>Current, and</i>	100%	3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%
	<i>least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>													
1.	<i>Is, to the extent reasonably possible, accurate</i>	100%												
2.	<i>Current, and</i>	100%												
3.	<i>Comprehensive: All sections are completed with at least the minimum information required in the instructions as applicable or indicate why the information is not available.</i>	100%												

Section D: Integrated Assessments

		<p>Current recommendation: Continue to monitor this requirement.</p>									
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 30% of the 30-Day Psychosocial Assessments due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 748 1892 899"> <tr> <td data-bbox="993 748 1087 821">4.</td> <td data-bbox="1087 748 1797 821"><i>Expressly identifies factual inconsistencies among sources.</i></td> <td data-bbox="1797 748 1892 821">100%</td> </tr> <tr> <td data-bbox="993 821 1087 862">5.</td> <td data-bbox="1087 821 1797 862"><i>Resolves or attempts to resolve inconsistencies.</i></td> <td data-bbox="1797 821 1892 862">100%</td> </tr> <tr> <td data-bbox="993 862 1087 899">6.</td> <td data-bbox="1087 862 1797 899"><i>Explains the rationale for the resolution offered.</i></td> <td data-bbox="1797 862 1892 899">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of the records of nine individuals to evaluate the 30-Day Psychosocial Assessments for documentation of factual inconsistencies found that eight assessments identified and resolved factual inconsistencies (ALB, CC, JAR, NB, RUS, SL, VRB and YJ) and one was unclear (CB). In the case of CB, a number of educational grades (8, 10, and 11) had been checked off, and it was unclear which was the highest grade completed.</p> <p>Compliance: Substantial.</p>	4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%	5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%	6.	<i>Explains the rationale for the resolution offered.</i>	100%
4.	<i>Expressly identifies factual inconsistencies among sources.</i>	100%									
5.	<i>Resolves or attempts to resolve inconsistencies.</i>	100%									
6.	<i>Explains the rationale for the resolution offered.</i>	100%									

Section D: Integrated Assessments

		<p>Current recommendation: Continue to monitor this requirement.</p>						
D.6.c	<p>Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 96% of Integrated Assessments: Social Work Sections due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 748 1892 786"> <tr> <td data-bbox="993 748 1087 786">7.</td> <td data-bbox="1087 748 1793 786"><i>Is included in the 7-day integrated assessment</i></td> <td data-bbox="1793 748 1892 786">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals to evaluate timeliness of the Social Work Integrated Assessment found that all nine assessments were timely (ALB, CB, CC, JAR, NB, RUS, SL, VRB and YJ).</p> <p>Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 30% of 30-Day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="993 1230 1892 1307"> <tr> <td data-bbox="993 1230 1087 1307">8.</td> <td data-bbox="1087 1230 1793 1307"><i>Fully documented by the 30th day of the individual's admission.</i></td> <td data-bbox="1793 1230 1892 1307">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	7.	<i>Is included in the 7-day integrated assessment</i>	98%	8.	<i>Fully documented by the 30th day of the individual's admission.</i>	99%
7.	<i>Is included in the 7-day integrated assessment</i>	98%						
8.	<i>Fully documented by the 30th day of the individual's admission.</i>	99%						

Section D: Integrated Assessments

		<p>A review of the records of nine individuals to evaluate timeliness of the 30-Day Psychosocial Assessments found that eight assessments were timely (ALB, CB, JAR, NB, RUS, SL, VRB and YJ) and one was untimely (CC).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Social History Assessments Monitoring Form, PSH assessed its compliance based on an average sample of 96% of 30-day Psychosocial Assessments due each month during the review period:</p> <table border="1" data-bbox="991 1003 1887 1081"> <tr> <td>9.</td> <td><i>Social factors</i></td> <td>100%</td> </tr> <tr> <td>10.</td> <td><i>Educational status</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of nine individuals to evaluate documentation of the individual's social factors and educational status in the 30-Day Psychosocial Assessments found that all nine assessments included such information (ALB, CB, CC, JAR, NB, RUS, SL, VRB and YJ).</p>	9.	<i>Social factors</i>	100%	10.	<i>Educational status</i>	100%
9.	<i>Social factors</i>	100%						
10.	<i>Educational status</i>	100%						

Section D: Integrated Assessments

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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Section D: Integrated Assessments

7. Court Assessments		
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:	As of the tour conducted in June 2009, PSH had maintained compliance with all of the requirements of this section for 18 months. The Court Monitor's evaluation of this section has therefore ceased per the terms of the Consent Judgment, and it will be the responsibility of DMH to provide oversight evaluation and ensure future maintenance of compliance.
D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	
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;	
D.7.a.iii	understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;	
D.7.a.iv	acceptance of mental illness and understanding of the need for treatment, both psychosocial and biological, and the need to adhere to treatment;	
D.7.a.v	development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;	
D.7.a.vi	willingness to achieve understanding of substance abuse issues and to develop an effective relapse prevention plan (as defined above);	
D.7.a.vii	previous community releases, if the individual has	

Section D: Integrated Assessments

	had previous CONREP revocations;	
D.7.a.viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	
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.	
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	
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;	
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	
D.7.b.iii	course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and	
D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	

Section D: Integrated Assessments

D.7.c	<p>Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.</p>	
D.7.c.i	<p>The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.</p>	

Section E: Discharge Planning and Community Integration

E. Discharge Planning and Community Integration		
		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has attained substantial compliance with all requirements of Section E. 2. The facility has increased its communication through education, training and consultation and collaboration with CONREP and other community entities to ensure that individuals are readily discharged upon meeting their discharge criteria.
E	<p>Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Hope Marriott, LCSW, Assistant to the Clinical Administrator 2. Lisa Hilder, LCSW, Supervisor Social Worker 3. Rachel Strydom, LCSW, Supervising Social Worker <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 31 individuals: AB, CCH, CCK, CED, DE, DPP, EK, EL, EWH, GM, JAH, JAR, JL, JLO, JM, JRP, JS, KA, KE, LH, MCD, MLB, MT, PLI, RRA, SCW, SL, SLC, STJ, TY and WMM 2. List of individuals referred for discharge but still hospitalized 3. List of individuals assessed to need family therapy 4. CONREP reports <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program IV, unit 34) for monthly review of MT 2. WRPC (Program IV, unit 43) for monthly review of STJ 3. WRPC (Program VI, unit EB-10) for quarterly review of CCH
E.1	<p>Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning</p>	<p>Please see sub-cells for compliance findings.</p>

Section E: Discharge Planning and Community Integration

	conferences, the particular considerations for each individual bearing on discharge, including:				
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 711 1890 824"> <tr> <td data-bbox="993 711 1087 824">1.</td> <td data-bbox="1087 711 1795 824"><i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i></td> <td data-bbox="1795 711 1890 824">96%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 11 individuals found that 10 WRPs utilized the individual's strengths, preferences, and life goals and that these were aligned with the intervention(s) that impacted the individual's discharge goals (AB, CED, DE, EWH, JM, JRP, JS, KE, PLI and SL). The individual's strengths, preferences, and life goals had not been appropriately utilized in the remaining one WRP (DPP).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	96%
1.	<i>Those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals.</i>	96%			

Section E: Discharge Planning and Community Integration

E.1.b	the individual's level of psychosocial functioning;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using 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 during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 597 1892 638"> <tr> <td data-bbox="991 597 1087 638">2.</td> <td data-bbox="1087 597 1793 638"><i>The individual's level of psychosocial functioning</i></td> <td data-bbox="1793 597 1892 638">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that eight WRPs included the individual's psychosocial functioning in the Present Status section (CCK, JAH, JL, JLO, JS, MLB, SCW and SLC). The documentation in the remaining WRP was not comprehensive (EWH).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>The individual's level of psychosocial functioning</i>	100%
2.	<i>The individual's level of psychosocial functioning</i>	100%			
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>			

Section E: Discharge Planning and Community Integration

		<p>Findings: Using 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 during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 414 1887 526"> <tr> <td data-bbox="993 414 1087 526">3.</td> <td data-bbox="1087 414 1793 526"><i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i></td> <td data-bbox="1793 414 1887 526">96%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of seven individuals found that all seven WRPs contained documentation of the current barriers preventing the individual from transitioning to a more integrated environment, difficulties in making progress, and progress the individual has made to this point (CED, DPP, EWH, JAH, JS, PLI and SL).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	96%
3.	<i>Any barriers preventing the individual from transitioning to more integrated environment, especially difficulties raised in previously unsuccessful placements.</i>	96%			
E.1.d	the skills and supports necessary to live in the setting in which the individual will be placed.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of</p>			

Section E: Discharge Planning and Community Integration

		<p>the quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 302 1887 378"> <tr> <td data-bbox="991 302 1087 378">4.</td> <td data-bbox="1087 302 1793 378"><i>The skills and supports necessary to live in the setting in which the individual will be placed.</i></td> <td data-bbox="1793 302 1887 378">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals found that all five WRPs documented the skills training and supports the individual needs to overcome barriers to discharge and successfully transition to the identified setting (DPP, EL, KE, MCD and RRA).</p> <p>Other findings: The SW department has prepared brochures on discharge supports and services in English and Spanish. The supports the individual will receive upon discharge to the community, or those which have not been arranged but will be needed will be entered into the brochure for individuals to take with them when they leave the facility to the next placement.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	100%
4.	<i>The skills and supports necessary to live in the setting in which the individual will be placed.</i>	100%			
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>			

Section E: Discharge Planning and Community Integration

		<p>Findings: Using the DMH WRP Observation Monitoring Form, PSH assessed its compliance based on an average sample of 16% of the quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 414 1887 636"> <tr> <td data-bbox="991 414 1087 636">12.</td> <td data-bbox="1087 414 1793 636"><i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i></td> <td data-bbox="1793 414 1887 636">99%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals found that all five WRPs contained documentation of the discharge barriers and the status of the individual's progress toward overcoming those barriers. However, only two of the WRPs contained documentation indicating that the individual was an active participant in the discharge process (GM and SCW), and the remaining three did not (JAH, JS and MLB).</p> <p>This monitor observed three WRPCs (CCH, MT and STJ). Where possible, given the individual's ability and willingness, the WRPTs engaged the individuals in discussing the discharge barriers and getting the individual's understanding and input. The WRPT did not get to review discharge barriers with MT because the individual walked out of the room (decompensated and became actively delusional) before the team got to the discharge section.</p> <p>A review of the records of eight individuals found that all eight WRPs contained measurable objectives and interventions to address the</p>	12.	<i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i>	99%
12.	<i>Each state hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.</i>	99%			

Section E: Discharge Planning and Community Integration

		<p>individual's discharge criteria (CCH, CED, DE, GM, JS, MT, SLC and STJ). A review of the records of same eight individuals found that all eight WRPs prioritized objectives and interventions related to the discharge processes with appropriate foci, objectives, and relevant PSR Mall services.</p> <p>As a suggestion for further improvement during the maintenance phase: in the WRPs reviewed, the WRPTs do a good job of outlining each discharge barrier with the status of the individual's progress towards the discharge criteria. It will be useful to provide a summary and analysis of the data indicating reasons for the lack of progress and the team recommendation to the individual and/or other entities for further progress.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:	Please see sub-cells for compliance findings.
E.3.a	measurable interventions regarding these discharge considerations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</p>

Section E: Discharge Planning and Community Integration

		<p>Findings: Using 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 during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 415 1892 748"> <tr> <td data-bbox="993 415 1087 672"></td> <td data-bbox="1087 415 1795 672"><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></td> <td data-bbox="1795 415 1892 672"></td> </tr> <tr> <td data-bbox="993 672 1087 748">6.</td> <td data-bbox="1087 672 1795 748"><i>Measurable interventions regarding these discharge considerations</i></td> <td data-bbox="1795 672 1892 748">92%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 74% in the previous review period.</p> <p>A review of the WRPs of seven individuals found that the objectives and discharge criteria were written in behavioral and/or measurable terms in all seven WRPs (CED, DPP, EWH, KE, PLI, SL and TY).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>		6.	<i>Measurable interventions regarding these discharge considerations</i>	92%
	<i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i>							
6.	<i>Measurable interventions regarding these discharge considerations</i>	92%						
E.3.b	the staff responsible for implement the interventions; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>						

Section E: Discharge Planning and Community Integration

		<p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 451 1890 527"> <tr> <td data-bbox="993 451 1087 527">7.</td> <td data-bbox="1087 451 1795 527"><i>The interventions specify the name(s) of specific staff responsible for implementing each one</i></td> <td data-bbox="1795 451 1890 527">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals found that all five WRPs identified the staff member responsible for the interventions (CED, DE, DPP, JAR and KE).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	100%
7.	<i>The interventions specify the name(s) of specific staff responsible for implementing each one</i>	100%			
E.3.c	The time frames for completion of the interventions.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Ensure that the review date for each objective is the same as the individual's next scheduled WRPC.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 21% of quarterly and annual WRPs due each month during the review period</p>			

Section E: Discharge Planning and Community Integration

		<p>(November 2009-April 2010):</p> <table border="1" data-bbox="991 264 1887 565"> <tr> <td data-bbox="991 264 1087 526"></td> <td data-bbox="1087 264 1793 526"> <p><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></p> </td> <td data-bbox="1793 264 1887 526"></td> </tr> <tr> <td data-bbox="991 526 1087 565">8.</td> <td data-bbox="1087 526 1793 565"> <p><i>The time frames for completion of interventions</i></p> </td> <td data-bbox="1793 526 1887 565">98%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of five individuals found that all five WRPs clearly stated the time frame for the next scheduled review for each intervention in the Mall or for individual therapy (AB, DE, DPP, JAR and KE).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<p><i>Each state hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge considerations, and that includes:</i></p>		8.	<p><i>The time frames for completion of interventions</i></p>	98%
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E.4	<p>Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:</p>	<p>Compliance: Substantial.</p>						
E.4.a	<p>individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p>						

Section E: Discharge Planning and Community Integration

		<p>Findings: Documentation review found that 22 individuals referred for discharge are still hospitalized. Ten of these individuals were referred for discharge within the last six months and 12 have been in the facility for more than six months following referral for discharge.</p> <table border="1" data-bbox="991 451 1885 1421"> <thead> <tr> <th data-bbox="991 451 1094 561">Name</th> <th data-bbox="1094 451 1241 561">Court Report Date</th> <th data-bbox="1241 451 1562 561">Status of availability of suitable placements.</th> <th data-bbox="1562 451 1885 561">Current Efforts to find placements</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 561 1094 786">TB</td> <td data-bbox="1094 561 1241 786">4/6/07</td> <td data-bbox="1241 561 1562 786">Immigration status remains a barrier. LA County Advocacy Services and pro bono attorney working on this issue.</td> <td data-bbox="1562 561 1885 786">WRPT members met with PSH Executive Director and individual's attorney</td> </tr> <tr> <td data-bbox="991 786 1094 935">TR</td> <td data-bbox="1094 786 1241 935">5/15/08</td> <td data-bbox="1241 786 1562 935">Re-referred for locked community facility and awaiting CONREP evaluation.</td> <td data-bbox="1562 786 1885 935">SW is following up with CONREP on the next interview date.</td> </tr> <tr> <td data-bbox="991 935 1094 1045">DVM</td> <td data-bbox="1094 935 1241 1045">3/10/09</td> <td data-bbox="1241 935 1562 1045">Waiting for further evaluation from CONREP.</td> <td data-bbox="1562 935 1885 1045">Following up with CONREP regarding interview.</td> </tr> <tr> <td data-bbox="991 1045 1094 1195">MW</td> <td data-bbox="1094 1045 1241 1195">4/30/09</td> <td data-bbox="1241 1045 1562 1195">CONREP did not accept. Court hearing pending.</td> <td data-bbox="1562 1045 1885 1195">SW is maintaining contact with CONREP regarding "locked" placement possibilities</td> </tr> <tr> <td data-bbox="991 1195 1094 1383">EK</td> <td data-bbox="1094 1195 1241 1383">9/18/09</td> <td data-bbox="1241 1195 1562 1383">Was originally denied by CONREP. WRPT persisted. Evaluated by CONREP in May and results are pending.</td> <td data-bbox="1562 1195 1885 1383">SW in regular contact with CONREP.</td> </tr> <tr> <td data-bbox="991 1383 1094 1421">MH</td> <td data-bbox="1094 1383 1241 1421">10/9/09</td> <td data-bbox="1241 1383 1562 1421">CONREP facilitating</td> <td data-bbox="1562 1383 1885 1421">SW facilitating</td> </tr> </tbody> </table>	Name	Court Report Date	Status of availability of suitable placements.	Current Efforts to find placements	TB	4/6/07	Immigration status remains a barrier. LA County Advocacy Services and pro bono attorney working on this issue.	WRPT members met with PSH Executive Director and individual's attorney	TR	5/15/08	Re-referred for locked community facility and awaiting CONREP evaluation.	SW is following up with CONREP on the next interview date.	DVM	3/10/09	Waiting for further evaluation from CONREP.	Following up with CONREP regarding interview.	MW	4/30/09	CONREP did not accept. Court hearing pending.	SW is maintaining contact with CONREP regarding "locked" placement possibilities	EK	9/18/09	Was originally denied by CONREP. WRPT persisted. Evaluated by CONREP in May and results are pending.	SW in regular contact with CONREP.	MH	10/9/09	CONREP facilitating	SW facilitating
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Section E: Discharge Planning and Community Integration

			interview with Southpoint facility.	Document completion
	LH	10/13/09	CONREP has not approved, instead has requested 3-6 months more treatment.	SW working towards direct discharge.
	KE	10/20/09	CONREP has not approved WRPT's recommendation.	WRPT trying to clarify with CONREP reasons for non-acceptance.
	DR	11/23/09	CONREP did not approve WRPT's recommendation and court date has not been set.	Court report complete. Referral Documents sent to CONREP.
	EL	12/18/09	CONREP approved. Awaiting court date.	SW has maintained contact with CONREP on recommendation status since 5/09.
	TC	12/29/09	Waiting for bed at CONREP.	Contact maintained with CONREP.
	MD	1/19/10	CONREP has not approved. WRPT will re-refer depending on court outcomes.	Sent referral packet
	BK	2/19/10	CONREP initiating interview between individual and Southpoint Program.	Initiating completion of physical exam per placement requirement.
	LL	2/23/10	CONREP has referred for placement at Southpoint.	Facilitating interview with Southpoint.
	NC	3/3/10	CONREP accepted. Waiting for the court	SW is preparing necessary documents

Section E: Discharge Planning and Community Integration

			order.		
		RA	3/18/10	WRPT recommended COT. May court date postponed. Immigration status is a barrier.	SW in contact with PD and family regarding immigration status.
		AF	3/25/10	IMD Referral completed. Waiting for response.	SW has made contact with IMD facility and completed necessary referral document.
		KM	4/5/10	Recent COT recommendation. Waiting for CONREP Evaluation.	CONREP referral face sheet and referral documents compiled.
		JC	4/16/10	COT Recommendation was rescinded as of 6/10/10.	Individual no longer meets discharge criteria per WRPT.
		CB	5/3/10	CONREP accepted. Waiting for open bed.	SW has worked with CONREP to provide necessary paperwork.
		VR	5/20/10	Court hearing in June 2010.	Preparing for community transition
		LS	8/07	COT court-ordered. CONREP cannot take due to Jessica's Law. CONREP asking court to remove Jessica's Law.	Referral for Vocational Rehab and SSI completed.
<p>As indicated in the table above, external factors such as CONREP denial, court hearing dates, and immigration issues are barriers to a speedier discharge in nearly all cases.</p>					

Section E: Discharge Planning and Community Integration

		<p>Current recommendation: Continue current practice.</p>			
E.4.b	Individuals receive adequate assistance in transitioning to the new setting.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Discharge Planning and Community Integration Auditing Form, PSH assessed its compliance based on an average sample of 100% of the quarterly and annual WRPs due each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 711 1890 935"> <tr> <td data-bbox="993 711 1087 935">10.</td> <td data-bbox="1087 711 1795 935"><i>[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] individuals receive adequate assistance in transitioning to the new setting.</i></td> <td data-bbox="1795 711 1890 935">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of eight individuals found that all eight WRPs contained documentation of the assistance needed by the individual in the new setting (EK, EL, KA, KE, LH, MCD, RRA and WMM). For example, arrangements for obtaining a California ID were made for EL; clothing was arranged for EK; contacts with SSI and DMV were made for MCD; and SSI and family assistance to obtain citizenship were provided for RRA, as well as resources arranged in the Philippines in the event the individual gets deported.</p>	10.	<i>[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] individuals receive adequate assistance in transitioning to the new setting.</i>	100%
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Section E: Discharge Planning and Community Integration

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

F. Specific Therapeutic and Rehabilitation Services	
	<p>Summary of Progress on Psychiatric Services: PSH has attained substantial compliance with all the requirements of Section F.1.</p> <p>Summary of Progress on Psychological Services: PSH has put in place a number of procedures to address validity and reliability of the By Choice incentive system including random checks to ensure that points are given after completion of activities and not before.</p> <p>Summary of Progress on Nursing Services:</p> <ol style="list-style-type: none">1. PSH has put significant efforts into the documentation of PRN and Stat medications and has achieved substantial compliance with this area of Section F.3.2. With continued efforts, PSH should be able to achieved substantial compliance with all of requirements in the area of Nursing Services by the next review. Efforts need to be directed at the nursing documentation addressing change of status. <p>Summary of Progress on Rehabilitation Therapy Services: PSH has maintained substantial compliance with the requirements of Section F.4 and should continue to enhance and improve current practice.</p> <p>Summary of Progress on Nutrition Assessments: PSH has maintained substantial compliance with the most requirements of Section F.5 with the exception of the requirement in cell F.5.b, and should continue efforts to enhance and improve current practice.</p> <p>Summary of Progress on Pharmacy Services: PSH has maintained substantial compliance with the requirements of Section F.6.</p>

Section F: Specific Therapeutic and Rehabilitation Services

	<p>Summary of Progress on General Medical Services: PSH has attained substantial compliance with all the requirements of Section F.7.</p> <p>Summary of Progress on Infection Control:</p> <ol style="list-style-type: none">1. PSH should be able to come into substantial compliance with all Enhancement Plan requirements by the next review with increased collaboration with Nursing to ensure that clinically sound and appropriate objectives and interventions are contained in the WRPs regarding diseases and collaboration with Standards Compliance regarding Key Indicator data.2. PSH's Infection Control Department continues to review its practices and update its policies and procedures in alignment with current standards of practices. <p>Summary of Progress on Dental Services PSH's Dental Department has achieved substantial compliance in all but one area of the Enhancement Plan: dental refusals. PSH has implemented a Corrective Action Team (CAT) to address hospital-wide appointment refusals. PSH's current efforts addressing this area should result in substantial compliance with the requirements of Section F.9 at the time of the next tour.</p>
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Section F: Specific Therapeutic and Rehabilitation Services

1. Psychiatric Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Andrew Blaine, MD, Staff Psychiatrist, Chief of Medical Staff 2. George Proctor, MD, Acting Psychopharmacology Consultant 3. Rebecca Kornbluh, MD, Acting Chief of Psychiatry <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 42 individuals: AJG, BBD, BMC, BRA, CAM, CCD, CG, COM, DBM, DML, EEE, EG, FMD, GA, GR, HEH, HME, JBW, JP, JPD, JW, KF, LAB, LDL, LEM, LG, LJH, MGG, MP-1, MP-2, OV, PEL, RNB, RSW, RWT, SBM, SBP, SH, SLK, TW, VEB, and VMC 2. PSH Admission Psychiatric Assessment Auditing summary data (November 2009-April 2010) 3. PSH Integrated Assessment: Psychiatry Section Auditing summary data (November 2009-April 2010) 4. PSH Monthly PPN Audit summary data (November 2009-April 2010) 5. PSH PRN and Stat monitoring summary data (November 2009-April 2010) 6. Number of individuals with Tardive Dyskinesia diagnosis on anticholinergics 7. PSH Tardive Dyskinesia database 8. PSH Polypharmacy database 9. PSH Movement Disorder Monitoring summary data (November 2009-April 2010) 10. PSH aggregated data regarding adverse drug reactions (November 2009-April 2010) 11. Last ten ADRs for this reporting period 12. ADR tracking sheet for the reporting period 13. PSH aggregated data regarding medication variances (November 2009-April 2010) 14. Last ten MVRs for this reporting period

Section F: Specific Therapeutic and Rehabilitation Services

		<p>15. MVR tracking sheet for the reporting period 16. Intensive case Analyses (ICAs) completed during this review period 17. MVR for ICA #2 dated 2/24/10 18. Drug Utilization Evaluations completed by PSH during this review period 19. Pharmacy and Therapeutics Committee Minutes (October 2009 to May 2010)</p>
F.1.a	<p>Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: PSH used the DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry Section and Monthly PPN Auditing Forms to assess its compliance, based on average samples of 48%, 25% and 21% respectively. Compliance data with corresponding indicators and sub-indicators and comparative data are summarized in each cell below</p> <p>Other findings: The following is a summary of the significant updates of the individualized medication guidelines (DMH Psychotropic Medication Policy) and other updates regarding medication uses in the facility's Pharmacy and Therapeutics Manual:</p> <ol style="list-style-type: none"> 1. Guidelines regarding iloperidone, olanzapine depot (Relprevv), first-generation antipsychotics and carbamazepine were added to the DMH Psychotropic Medication Policy. 2. The clozapine guideline was updated to include a procedure for its use for terminally ill individuals in hospice care.

Section F: Specific Therapeutic and Rehabilitation Services

		<p>3. Prasugrel (Effient) was added to the PSH Pharmacy and Therapeutics Manual as an anticoagulant.</p> <p>4. A guideline for the use of zonisamide was added to the Manual.</p> <p>5. Antimicrobial Therapy guideline was updated, including the use of newer antimicrobials (the Sanford Guideline to Antimicrobial Therapy, 2009 was used as a reference).</p> <p>A review of the updates in the DMH Psychotropic Medication Policy found that the updates comported with current generally accepted standards.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that the individualized medication guidelines are continually updated, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. Provide a summary outline of the updates during the review period. 2. Continue to monitor this requirement. 												
F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	<table border="1" data-bbox="991 971 1890 1193"> <thead> <tr> <th colspan="3">Admission Psychiatric Assessment</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1011 1087 1193">8.</td> <td data-bbox="1087 1011 1795 1193"><i>Plan of care includes [regular psychotropic medications, with rationale; PRN and/or Stat medications, as applicable, with specific behavioral indicators; and special precautions to address risk factors, as indicated].</i></td> <td data-bbox="1795 1011 1890 1193">99%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <table border="1" data-bbox="991 1344 1890 1421"> <thead> <tr> <th colspan="3">Integrated Psychiatric Assessment</th> </tr> </thead> <tbody> <tr> <td data-bbox="991 1385 1087 1421">7.</td> <td data-bbox="1087 1385 1795 1421"><i>Diagnostic formulation</i></td> <td data-bbox="1795 1385 1890 1421">98%</td> </tr> </tbody> </table>	Admission Psychiatric Assessment			8.	<i>Plan of care includes [regular psychotropic medications, with rationale; PRN and/or Stat medications, as applicable, with specific behavioral indicators; and special precautions to address risk factors, as indicated].</i>	99%	Integrated Psychiatric Assessment			7.	<i>Diagnostic formulation</i>	98%
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Section F: Specific Therapeutic and Rehabilitation Services

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F.1.a.ii	prescribed in therapeutic amounts, as dictated by the needs of the individual served;	<table border="1" style="width: 100%;"> <tr> <td colspan="3">Monthly PPN</td> </tr> <tr> <td style="width: 5%;">5.b</td> <td style="width: 80%;"><i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i></td> <td style="width: 15%;">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.b	<i>Current regimen is prescribed consistent with DMH Psychotropic guidelines.</i>	100%						
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Section F: Specific Therapeutic and Rehabilitation Services

F.1.a.iv	monitored for effectiveness against clearly identified target variables and time frames;	<table border="1" data-bbox="991 228 1887 342"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.c</td> <td><i>Monitored for effectiveness against clearly identified target variables</i></td> <td>99%</td> </tr> </table> <p data-bbox="991 386 1887 456">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.c	<i>Monitored for effectiveness against clearly identified target variables</i>	99%			
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F.1.a.v	monitored appropriately for side effects;	<table border="1" data-bbox="991 529 1887 867"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>2.g</td> <td><i>Current AIMS</i></td> <td>99%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>95%</td> </tr> </table> <p data-bbox="991 911 1887 980">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p>	Monthly PPN			2.g	<i>Current AIMS</i>	99%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	95%
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F.1.a.vi	modified based on clinical rationales;	<table border="1" data-bbox="991 1055 1887 1424"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.a</td> <td><i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i></td> <td>99%</td> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric</i></td> <td>95%</td> </tr> </table>	Monthly PPN			5.a	<i>Justify/explain the current regimen considering this month's progress (or lack of progress) and clinical data</i>	99%	5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric</i>	95%
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Section F: Specific Therapeutic and Rehabilitation Services

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F.1.a.vii	are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and	<table border="1"> <tr> <th colspan="3">Monthly PPN</th> </tr> <tr> <td>5.d</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i></td> <td>95%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p>	Monthly PPN			5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	95%						
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5.d	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following: benzodiazepines, anticholinergics, polypharmacy, conventional and atypical antipsychotics and other psychiatric medications.</i>	95%												
F.1.a.viii	Properly documented.	<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Admission Psychiatric Assessment</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>Integrated Assessment (Psychiatry)</td> <td>94%</td> <td>99%</td> </tr> <tr> <td>Monthly PPN</td> <td>98%</td> <td>98%</td> </tr> </tbody> </table>		Previous period	Current period	Admission Psychiatric Assessment	99%	99%	Integrated Assessment (Psychiatry)	94%	99%	Monthly PPN	98%	98%
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F.1.b	Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p>												

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Findings:

PSH used the standardized DMH Monthly PPN tool to assess its compliance, based on an average sample of 21% of individuals who have been hospitalized for 90 or more days during the review period (November 2009-April 2010). The facility also used the DMH Nursing Services Monitoring Forms for PRN and Stat medication uses, based on average samples of 20% and 24% of PRN and Stat medications given per month, respectively. The following tables summarize the data:

Monthly PPN		
6.	<i>Timely review of the use of "pro re nata" or "as needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use.</i>	99%

Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.

Nursing Services PRN		
1.	<i>Safe administration of PRN medication.</i>	94%
2.	<i>Documentation of the circumstances requiring PRN medication.</i>	97%
3.	<i>Documentation of the individual's response to PRN medication.</i>	92%

Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for items 1 and 2. The compliance rate for item 3 improved from 83% in the previous review period.

Nursing Services Stat		
1.	<i>Safe administration of Stat medication.</i>	98%
2.	<i>Documentation of the circumstances requiring Stat</i>	96%

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		<table border="1" data-bbox="991 188 1887 305"> <tr> <td data-bbox="991 188 1087 228"></td> <td data-bbox="1087 188 1793 228"><i>medication.</i></td> <td data-bbox="1793 188 1887 228"></td> </tr> <tr> <td data-bbox="991 228 1087 305">3.</td> <td data-bbox="1087 228 1793 305"><i>Documentation of the individual's response to Stat medication.</i></td> <td data-bbox="1793 228 1887 305">90%</td> </tr> </table> <p data-bbox="991 347 1887 488">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for items 1 and 2. The compliance rate for item 3 improved from 83% in the previous review period.</p> <p data-bbox="991 532 1423 602">Other findings: See this monitor's findings in D.1.f.</p> <p data-bbox="991 646 1142 711">Compliance: Substantial.</p> <p data-bbox="991 755 1457 820">Current recommendation: Continue to monitor this requirement.</p>		<i>medication.</i>		3.	<i>Documentation of the individual's response to Stat medication.</i>	90%
	<i>medication.</i>							
3.	<i>Documentation of the individual's response to Stat medication.</i>	90%						
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	<p data-bbox="991 868 1591 901">Current findings on previous recommendations:</p> <p data-bbox="991 943 1854 1084">Recommendation 1, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p data-bbox="991 1128 1904 1344">Findings: PSH used the standardized DMH Monthly PPN Audit Form to assess its compliance (November 2009-April 2010). Sample size was based on the total number of individuals prescribed the class of medication, regardless of duration. The following is a summary of the monitoring indicators and corresponding mean compliance rates:</p>						

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		<table border="1"> <thead> <tr> <th colspan="3">PPN - Revised</th> </tr> </thead> <tbody> <tr> <td>5.d.</td> <td><i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i></td> <td></td> </tr> <tr> <td>5.d.i.</td> <td><i>Benzodiazepines. (%S = 14%)</i></td> <td>93%</td> </tr> <tr> <td>5.d.ii.</td> <td><i>Anticholinergics. (%S = 9%)</i></td> <td>92%</td> </tr> <tr> <td>5.d.iii.</td> <td><i>Polypharmacy. (%S = 14%)</i></td> <td>95%</td> </tr> </tbody> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Recommendation 2, December 2009: Continue to provide comparative data regarding the following:</p> <ol style="list-style-type: none"> Total number of individuals receiving benzodiazepines for 60 days or more; Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more; Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more; Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning); Total number receiving anticholinergics for 60 days or more; Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above; Total number receiving intra-class polypharmacy; and Total number receiving inter-class polypharmacy. <p>Findings: PSH reported the following comparative data:</p>	PPN - Revised			5.d.	<i>Justify/explain the use of medications that pose elevated risks and/or are causing side effects including, if applicable, an analysis of risks and benefits of the following:</i>		5.d.i.	<i>Benzodiazepines. (%S = 14%)</i>	93%	5.d.ii.	<i>Anticholinergics. (%S = 9%)</i>	92%	5.d.iii.	<i>Polypharmacy. (%S = 14%)</i>	95%
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	Indicators	Previous Period	Current Period
1.	<i>Total number of individuals receiving benzodiazepines for 60 days or more</i>	94	39
2.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (a) any substance, for 60 days or more</i>	59	24
3.	<i>Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more</i>	50	24
4.	<i>Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning)</i>	13	8
5.	<i>Total number receiving anticholinergics for 60 days or more</i>	129	143
6.	<i>Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above</i>	21	32
7.	<i>Total number with intra-class polypharmacy</i>	387	251
8.	<i>Total number with inter-class polypharmacy</i>	184	164

The above data showed significant decreases in the number of individuals receiving high-risk treatment with benzodiazepines and the number of individuals receiving polypharmacy.

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		<p>Other findings: This monitor reviewed the facility's databases regarding individuals receiving long-term treatment with the following types of medication use:</p> <ol style="list-style-type: none"> 1. Benzodiazepines in presence of diagnoses of substance use disorders and/or cognitive disorders; 2. Anticholinergic medications for individuals diagnosed with cognitive disorders; 3. Anticholinergic medications for elderly individuals; and 4. Various forms of polypharmacy. <p>The reviews verified the facility's data regarding the decrease in the numbers of individuals receiving high risk treatment with benzodiazepines and receiving polypharmacy.</p> <p>This monitor also reviewed the charts of individuals receiving the above types of medication regimens. The following is an outline of the chart reviews:</p> <p><u>Benzodiazepine use</u></p> <table border="1" data-bbox="989 967 1883 1385"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BMC</td> <td>Clonazepam (discontinued)</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>BRA</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>GA</td> <td>Lorazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>JBW</td> <td>Lorazepam</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>JW</td> <td>Lorazepam</td> <td>Cocaine Dependence</td> </tr> <tr> <td>KF</td> <td>Lorazepam</td> <td>Nicotine Dependence</td> </tr> <tr> <td>MGG</td> <td>Clonazepam</td> <td>Polysubstance Dependence</td> </tr> <tr> <td>PEL</td> <td>Clonazepam</td> <td>Dementia Due to General Medical Condition with Behavioral Disturbance</td> </tr> </tbody> </table>	Individual	Medication(s)	Diagnosis	BMC	Clonazepam (discontinued)	Polysubstance Dependence	BRA	Lorazepam	Polysubstance Dependence	GA	Lorazepam	Polysubstance Dependence	JBW	Lorazepam	Cognitive Disorder NOS	JW	Lorazepam	Cocaine Dependence	KF	Lorazepam	Nicotine Dependence	MGG	Clonazepam	Polysubstance Dependence	PEL	Clonazepam	Dementia Due to General Medical Condition with Behavioral Disturbance
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		RNB	Clonazepam	Borderline Intellectual Functioning, Amphetamine Dependence and Drug-Induced Psychosis																																	
		SLK	Clonazepam	Polysubstance Dependence																																	
		<p>This review found substantial compliance in the charts of BMC, GA, JW, KF, MGG, RNB and SLK and partial compliance in the charts of BRA, JBW and PEL.</p> <p><u>Anticholinergic use</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>BBD</td> <td>Benztropine</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>LAB</td> <td>Benztropine</td> <td>Cognitive Disorder NOS</td> </tr> <tr> <td>NP</td> <td>Benztropine discontinued</td> <td>Borderline Intellectual Functioning</td> </tr> <tr> <td>RWT</td> <td>Benztropine (and clozapine)</td> <td>Borderline Intellectual Functioning and Constipation</td> </tr> <tr> <td>VMC</td> <td>Diphenhydramine</td> <td>Borderline Intellectual Functioning</td> </tr> </tbody> </table> <p>This review found substantial compliance in the charts of LAB, NP and VMC and partial compliance in the charts of BBD and RWT.</p> <p><u>Anticholinergic use for elderly individuals</u></p> <table border="1"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>CAM</td> <td>Hydroxyzine</td> <td></td> </tr> <tr> <td>CCD</td> <td>Benzotropine (and clonazepam)</td> <td></td> </tr> <tr> <td>COM</td> <td>Trihexyphenidyl (and clonazepam)</td> <td></td> </tr> <tr> <td>EG</td> <td>Benzotropine</td> <td>Dementia NOS</td> </tr> </tbody> </table>			Individual	Medication(s)	Diagnosis	BBD	Benztropine	Borderline Intellectual Functioning	LAB	Benztropine	Cognitive Disorder NOS	NP	Benztropine discontinued	Borderline Intellectual Functioning	RWT	Benztropine (and clozapine)	Borderline Intellectual Functioning and Constipation	VMC	Diphenhydramine	Borderline Intellectual Functioning	Individual	Medication(s)	Diagnosis	CAM	Hydroxyzine		CCD	Benzotropine (and clonazepam)		COM	Trihexyphenidyl (and clonazepam)		EG	Benzotropine	Dementia NOS
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		<p>diagnosis of substance abuse: (a) any substance, for 60 days or more;</p> <p>c) Total number of individuals receiving benzodiazepines and having a diagnosis of substance abuse: (b) poly/alcohol, for 60 days or more;</p> <p>d) Total number receiving benzodiazepines and having cognitive impairments (dementia or MR or cognitive disorder NOS or borderline intellectual functioning);</p> <p>e) Total number receiving anticholinergics for 60 days or more;</p> <p>f) Total number receiving anticholinergics and having a diagnosis of cognitive impairments (as above) or tardive dyskinesia or age 65 or above;</p> <p>g) Total number receiving intra-class polypharmacy; and</p> <p>h) Total number receiving inter-class polypharmacy.</p>												
F.1.d	<p>Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Monthly PPN Auditing Form, PSH assessed its compliance based on an average sample of 21% of individuals receiving these medications during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1117 1911 1344"> <tr> <td>5.d.v</td> <td><i>Atypical antipsychotics with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical except for aripiprazole and ziprasidone</i></td> <td>98%</td> </tr> <tr> <td>5.d.v.i</td> <td><i>Dyslipidemia</i></td> <td>97%</td> </tr> <tr> <td>5.d.v.ii</td> <td><i>Diabetes Mellitus</i></td> <td>98%</td> </tr> <tr> <td>5.d.v.iii</td> <td><i>Obesity</i></td> <td>98%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at</p>	5.d.v	<i>Atypical antipsychotics with specific emphasis on risk for dyslipidemia, diabetes mellitus, and obesity for all atypical except for aripiprazole and ziprasidone</i>	98%	5.d.v.i	<i>Dyslipidemia</i>	97%	5.d.v.ii	<i>Diabetes Mellitus</i>	98%	5.d.v.iii	<i>Obesity</i>	98%
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		<p>least 90% from the previous review period for all items.</p> <p>Recommendation 2, December 2009: Ensure documentation of adequate clinical monitoring of individuals at risk for endocrine dysfunction.</p> <p>Findings: See Other Findings below.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals who are receiving new-generation antipsychotic agents and suffering from a variety of metabolic disorders. The following table outlines the initials of these individuals, the medication(s) used and the metabolic disorder(s):</p> <table border="1" data-bbox="991 743 1873 1352"> <thead> <tr> <th>Individual</th> <th>Medication(s)</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td>DBM</td> <td>Olanzapine</td> <td>Diabetes Mellitus and Obesity</td> </tr> <tr> <td>EEE</td> <td>Risperidone</td> <td>Diabetes Mellitus and Obesity</td> </tr> <tr> <td>JP</td> <td>Olanzapine and risperidone</td> <td>Diabetes Mellitus and Hyperlipidemia compliant</td> </tr> <tr> <td>JW</td> <td>Risperidone</td> <td>Hyperprolactinemia compliant</td> </tr> <tr> <td>LEM</td> <td>Clozapine</td> <td>Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension</td> </tr> <tr> <td>LJH</td> <td>Clozapine</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>MP</td> <td>Quetiapine</td> <td>Diabetes Mellitus and Obesity</td> </tr> <tr> <td>SBM</td> <td>Quetiapine and haloperidol</td> <td>Diabetes Mellitus and Hyperlipidemia</td> </tr> <tr> <td>SH</td> <td>Olanzapine</td> <td>Diabetes Mellitus</td> </tr> <tr> <td>SK</td> <td>Olanzapine and risperidone</td> <td>Hyperprolactinemia and Hyperlipidemia</td> </tr> </tbody> </table> <p>This review found substantial compliance in all cases.</p>	Individual	Medication(s)	Diagnosis	DBM	Olanzapine	Diabetes Mellitus and Obesity	EEE	Risperidone	Diabetes Mellitus and Obesity	JP	Olanzapine and risperidone	Diabetes Mellitus and Hyperlipidemia compliant	JW	Risperidone	Hyperprolactinemia compliant	LEM	Clozapine	Diabetes Mellitus, Hyperlipidemia, Obesity and Hypertension	LJH	Clozapine	Diabetes Mellitus	MP	Quetiapine	Diabetes Mellitus and Obesity	SBM	Quetiapine and haloperidol	Diabetes Mellitus and Hyperlipidemia	SH	Olanzapine	Diabetes Mellitus	SK	Olanzapine and risperidone	Hyperprolactinemia and Hyperlipidemia
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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>															
F.1.e	<p>Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Movement Disorders Auditing Form, PSH assessed its compliance based on average samples ranging from 21% to 48% of individuals relevant to each indicator during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 933 1890 1421"> <tr> <td data-bbox="991 933 1087 1008">1.</td> <td data-bbox="1087 933 1793 1008"><i>A baseline assessment shall be performed for each individual at admission.</i></td> <td data-bbox="1793 933 1890 1008">98%</td> </tr> <tr> <td data-bbox="991 1008 1087 1122">2.</td> <td data-bbox="1087 1008 1793 1122"><i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i></td> <td data-bbox="1793 1008 1890 1122">99%</td> </tr> <tr> <td data-bbox="991 1122 1087 1235">3.</td> <td data-bbox="1087 1122 1793 1235"><i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i></td> <td data-bbox="1793 1122 1890 1235">99%</td> </tr> <tr> <td data-bbox="991 1235 1087 1310">4.</td> <td data-bbox="1087 1235 1793 1310"><i>All individuals with movement disorders are appropriately treated.</i></td> <td data-bbox="1793 1235 1890 1310">100%</td> </tr> <tr> <td data-bbox="991 1310 1087 1421">5.</td> <td data-bbox="1087 1310 1793 1421"><i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i></td> <td data-bbox="1793 1310 1890 1421">90%</td> </tr> </table>	1.	<i>A baseline assessment shall be performed for each individual at admission.</i>	98%	2.	<i>Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.</i>	99%	3.	<i>Monitoring of the individual is conducted every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.</i>	99%	4.	<i>All individuals with movement disorders are appropriately treated.</i>	100%	5.	<i>A neurology consultation/Movement Disorders Clinic evaluation was completed as for all individuals with complicated movement disorders.</i>	90%
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		<table border="1"> <tr> <td data-bbox="989 190 1087 266">6.</td> <td data-bbox="1087 190 1793 266"><i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i></td> <td data-bbox="1793 190 1890 266">91%</td> </tr> <tr> <td data-bbox="989 266 1087 342">7.</td> <td data-bbox="1087 266 1793 342"><i>The Movement Disorder is included in Focus 6 of the WRP.</i></td> <td data-bbox="1793 266 1890 342">95%</td> </tr> <tr> <td data-bbox="989 342 1087 418">8.</td> <td data-bbox="1087 342 1793 418"><i>The WRP reflects objectives and interventions for the Movement Disorder.</i></td> <td data-bbox="1793 342 1890 418">95%</td> </tr> </table>	6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	91%	7.	<i>The Movement Disorder is included in Focus 6 of the WRP.</i>	95%	8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	95%	<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: The facility's database identified 70 individuals as meeting one or more of the following three criteria: current diagnosis of TD, history of TD or current abnormal AIMS score. This monitor reviewed the charts of six individuals (CG, DML, FMD, GR, LDL and LG) currently diagnosed with Tardive Dyskinesia. The review found further progress since the last review. The following are examples:</p> <ol style="list-style-type: none"> 1. Admission AIMS tests were completed on all individuals who were admitted during the past year. 2. Quarterly AIMS monitoring was completed in all charts reviewed. 3. The WRPs included diagnosis, focus and corresponding objectives and interventions related to tardive dyskinesia in all charts reviewed. 4. The psychiatric progress notes contained evidence of tracking of the status of TD in all charts reviewed. 5. The objectives related to TD utilized appropriate learning outcomes for most individuals (CG, DML, FMD, LDL and LG). 6. All charts documented attempts to use safer treatment alternatives for the individuals, including clozapine (CG and GR). 7. None of the individuals diagnosed with TD received unnecessary long-term treatment with anticholinergic agents during this review period. <p>The review found a few deficiencies:</p>
6.	<i>Diagnosis of Movement Disorder is listed on Axis I and/or III (for current diagnosis).</i>	91%										
7.	<i>The Movement Disorder is included in Focus 6 of the WRP.</i>	95%										
8.	<i>The WRP reflects objectives and interventions for the Movement Disorder.</i>	95%										

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		<p>1. One WRP included an unattainable objective for the individual (GR). 2. The quarterly AIMS ratings appeared to unreliable in one chart (GR).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.1.f	<p>Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Increase reporting of ADRs.</p> <p>Findings: During this review period, PSH reported 155 ADRs compared to 144 during the previous review period.</p> <p>Recommendation 2, December 2009: Continue review and analysis of ADRs and present summary of aggregated data to address the following:</p> <ol style="list-style-type: none"> a. The number of ADRs reported each month during the review period compared with number reported during the previous period; b. Classification of probability and severity of ADRs; c. Any negative outcomes for individuals who were involved in serious reactions; d. Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; and e. Any Intensive Case Analysis done, including review of circumstances of the events, contributing factors, conclusions regarding preventability and any possible process deficiencies; and specific recommendations for corrective actions (full report).

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		<p>Findings: The following summarizes the facility's data:</p> <table border="1" data-bbox="991 337 1887 797"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Total ADRs</td> <td>147</td> <td>155</td> </tr> <tr> <td colspan="3">Classification of Probability of ADRs</td> </tr> <tr> <td>Doubtful</td> <td>33</td> <td>34</td> </tr> <tr> <td>Possible</td> <td>58</td> <td>53</td> </tr> <tr> <td>Probable</td> <td>47</td> <td>51</td> </tr> <tr> <td>Definite</td> <td>9</td> <td>17</td> </tr> <tr> <td colspan="3">Classification of Severity of ADRS</td> </tr> <tr> <td>Mild</td> <td>79</td> <td>91</td> </tr> <tr> <td>Moderate</td> <td>61</td> <td>59</td> </tr> <tr> <td>Severe</td> <td>7</td> <td>5</td> </tr> </tbody> </table> <p>Of the five severe ADRs, none resulted in permanent sequelae to the individual involved. PSH conducted intensive case analyses (ICAs) on all severe ADRs. The ICAs employed appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate. The following is a summary of the corrective actions that addressed these incidents:</p> <ol style="list-style-type: none"> 1. Nursing education regarding policy to discontinue/renew medication upon return from PSH absences; 2. Educational presentations to medical staff regarding the identification and management of delirium; and 3. Educational presentations to medical staff regarding drug-drug interactions involving lithium and dosing strategies for the use of anticonvulsants for individuals suffering from seizure disorders. 		Previous period	Current period	Total ADRs	147	155	Classification of Probability of ADRs			Doubtful	33	34	Possible	58	53	Probable	47	51	Definite	9	17	Classification of Severity of ADRS			Mild	79	91	Moderate	61	59	Severe	7	5
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		<p>Recommendation 3, December 2009: Continue to provide analysis of patterns and trends, with corrective/educational actions related to ADRs.</p> <p>Findings: The facility's review of patterns of ADRs during this review period showed that most of the reactions involved extrapyramidal signs. Additional reports of orthostatic hypotension resulted in educational presentation to the medical staff in January 2010. The above-mentioned educational/corrective measures were implemented in response to the ICAs of severe ADRs. These actions were appropriate.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Increase reporting of ADRs.2. Continue review and analysis of ADRs and present summary of aggregated data to address the following:<ol style="list-style-type: none">a) The number of ADRs reported each month during the review period compared with number reported during the previous period;b) Classification of probability and severity of ADRs;c) Any negative outcomes for individuals who were involved in serious reactions;d) Data analysis regarding patterns and trends of ADRs, including recommendations for corrective actions; ande) 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).
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<p>F.1.g</p>	<p>Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all psychotropic medications; the guidelines shall be in accord with current professional literature.</p> <p>A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p> <p>Findings: PSH reported that it completed DUEs on lithium plasma levels, olanzapine fasting glucose and HgbA1C levels and phenytoin plasma levels.</p> <p>Other findings: Review by this monitor found that the facility's DUEs employed appropriate methodologies and comported with generally accepted standards for this process.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to provide summary data on DUEs conducted during the review period, including topic, findings, recommendations and actions taken.</p>
<p>F.1.h</p>	<p>Each State hospital shall ensure documentation, reporting, data analyses, and follow-up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Continue to present data to address the following:</p> <ol style="list-style-type: none"> a. Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b. Total number of actual and potential variances during the review period compared with numbers reported during the previous period; c. Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc);

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

Findings:

PSH reported the following data regarding MVRs:

Number of Medication Variances	Previous Period	Current Period
Prescribing	18	29
Transcribing	93	146
Ordering/Procurement	125	42
Dispensing	153	176
Administration	238	212
Drug Security	171	2
Documentation	113	623
Total variances	911	1,230

Total Critical Breakdown Points	Previous Period	Current Period
Total Critical Breakdown Points	648	1,127
Potential MVRs	360	902
Actual MVRs	288	225
# Prescribing	18	29
# Transcribing	89	133
# Order/Procure	106	41

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		<table border="1"> <tr> <td># Dispensing</td> <td>131</td> <td>165</td> </tr> <tr> <td># Administration</td> <td>119</td> <td>139</td> </tr> <tr> <td># Drug Security</td> <td>124</td> <td>2</td> </tr> <tr> <td># Document</td> <td>61</td> <td>618</td> </tr> <tr> <td>Outcome A</td> <td>353</td> <td>536</td> </tr> <tr> <td>Outcome B</td> <td>30</td> <td>364</td> </tr> <tr> <td>Outcome C</td> <td>261</td> <td>220</td> </tr> <tr> <td>Outcome D</td> <td>4</td> <td>6</td> </tr> <tr> <td>Outcome E</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome F</td> <td>0</td> <td>1</td> </tr> <tr> <td>Outcome G</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome H</td> <td>0</td> <td>0</td> </tr> <tr> <td>Outcome I</td> <td>0</td> <td>0</td> </tr> </table> <p>The above data showed significant improvement in the facility's capacity to capture potential variances compared to previous review periods.</p> <p>The data regarding total number of variances in different categories showed slight differences in a few categories (e.g. dispensing and administration) compared to the data provided in the key indicators. The facility investigated this matter and found that the majority of discrepancies were due to data entry problems; corrective measures have been initiated.</p> <p>PSH completed ICAs of the two variances that met threshold for analysis during this review period. The ICAs employed appropriate methodology and the recommendations for systemic corrective/educational actions were generally adequate. The following is a summary of the corrective actions that addressed the two incidents:</p> <ol style="list-style-type: none"> 1. Counseling and informal training of nursing staff regarding failure to monitor blood pressure as ordered; 2. Improved nursing oversight regarding proper documentation of vital 	# Dispensing	131	165	# Administration	119	139	# Drug Security	124	2	# Document	61	618	Outcome A	353	536	Outcome B	30	364	Outcome C	261	220	Outcome D	4	6	Outcome E	0	0	Outcome F	0	1	Outcome G	0	0	Outcome H	0	0	Outcome I	0	0
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		<p>signs on the medication treatment records;</p> <ol style="list-style-type: none"> 3. Staff education regarding safeguards to prevent the administration of a medication to which the individual is reportedly allergic; and 4. Improved pharmacy oversight to check for documented allergy prior to filling orders. <p>Recommendation 2, December 2009: Continue to provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p> <p>Findings: PSH reported a variety of corrective measures to address patterns/ trends of variances in the categories of documentation, administration, dispensing and transcription. In general, the corrective actions were appropriate.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to present data to address the following: <ol style="list-style-type: none"> a) Total number of variances and total number of critical breakdown points during the review period compared with numbers reported during the previous review period; b) Total number of actual and potential variances during the review period compared with numbers reported during the previous period; c) Number of variances and critical breakdown points by category (e.g. prescription, administration, documentation, etc); d) Number of critical breakdown points by outcome; e) Clinical information regarding each variance (category E or above) and the outcome to the individual involved; f) Information regarding any intensive case analysis done for each
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		<p>reaction that was classified as category E or above; and</p> <p>g) Outline of ICAs, including description of variance, recommendations and actions taken.</p> <p>2. Continue to provide analysis of patterns and trends, with corrective/ educational actions related to MVRs.</p>
F.1.i	<p>Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Same as in F.1.a through F.1.h.</p> <p>Findings: Same as in F.1.a through F.1.h.</p> <p>In addition, PSH reported that its senior psychiatrists have reviewed and analyzed data on individual practitioners, performed annual reviews, formal counseling, and informal counseling based upon quality of care and documentation lapses and generated three reports to the Medical Executive Committee on identified concerns. As mentioned in Section D.1, the process of reprivileging of psychiatrists considers all audit data as well as MVR and ADR reports.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Same as in F.1.a through F.1.h.</p>
F.1.j	<p>Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Same as in F.1.a through F.1.h.</p>

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

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

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		<p>Recommendation, December 2009: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Same as above.</p> <p>Findings: Same as above.</p> <p>Current recommendation: Same as above.</p>
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Same as F.1.e.</p> <p>Findings: Same as F.1.e.</p> <p>Current recommendations: Same as F.1.e.</p>
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who	<p>Current findings on previous recommendation:</p>

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	are prescribed new generation antipsychotic medications	<p>Recommendation, December 2009: Same as in F.1.d. and F.1.g.</p> <p>Findings: Same as in F.1.d. and F.1.g.</p> <p>Current recommendations: Same as in F.1.d. and F.1.g.</p>
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Same as in C.2.o and F.1.c.</p> <p>Findings: Same as in C.2.o and F.1.c.</p> <p>Compliance: Substantial.</p> <p>Current recommendations: Same as in C.2.o and F.1.c.</p>
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.	<p>This requirement applies exclusively to Metropolitan State Hospital.</p>

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2. Psychological Services	
	<p>Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:</p>
	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Allison Pate, PhD, Senior Supervising Psychologist 2. David Haimson, PhD, Chief of Psychology 3. Gari-Lyn Richardson, Director of Standards Compliance 4. Helga Thordarson, PhD, Senior Supervising Psychologist 5. Hope Marriott, LCSW, Social Worker, Assistant to the Clinical Administrator 6. Melanie Byde, PhD, Psychologist, Mall Director 7. Steve Berman, PhD, By Choice Coordinator 8. Susan Valesquez, PhD, PSSC Coordinator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 24 individuals: AB, ALA, AS, DF, DG, DK, DLR, EG, FS, GB, GJ, HDM, JA, JC, JL, JP, KA, KDP, KM, MLB, RJ, SA, TG, and VF 2. Behavioral guidelines developed and implemented in the last six months 3. Positive Behavior Support Plans developed and implemented in the last six months 4. By Choice Training Documents 5. Proposal to integrate By Choice program into weight management goals. 6. Guidelines for By Choice point ratings during Mall group participation. 7. List of staff trained to implement Positive Behavior Support Plans. 8. List of individuals identified as needing neuropsychological services 9. Neuropsychological assessments completed in the last six months 10. List of individuals reviewed by the Psychology Specialized Services Committee (PSSC) 11. PSSC reports 12. List of individuals receiving DCAT services

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		<p>13. 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</p> <p>14. Structural and functional assessments completed in the last six months</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program IV, unit 34) for monthly review of MT 2. WRPC (Program IV, unit 43) for monthly review of STJ 3. WRPC (Program VI, unit EB-10) for quarterly review of CCH 4. Mall Group: Creative Art Therapy 5. Mall Group: Cognitive Remediation 6. Mall Group: WRAP 7. Mall Group: Cognitive Remediation Group (RISE) 8. Mall Group: Medication Education 9. Mall Group: Coping Skills 10. Mall Group: Social Skills
F.2.a	<p>Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Ensure the required number of PBS teams to meet the 1:300 ratio.</p> <p>Findings: PSH has four PBS teams and one DCAT team. Together these teams meet the required 1:300 ratio. Staff in one PBS team was recently hired. None of the PBS/DCAT teams have data analysts. It appears that these positions were not allocated. However, PSH has hired a graduate student to assist in data analysis.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Ensure that all PBS/DCAT positions are filled.</p>																																																
<p>F.2.a.i</p>	<p>the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The table below showing the number of new direct care staff at PSH (N), the number of new direct care staff trained for each month of this review period (n), and the percent staff trained (%C) is a summary of the facility's data:</p> <table border="1" data-bbox="991 711 1906 941"> <thead> <tr> <th colspan="8">Staff Training</th> </tr> <tr> <th></th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>N</td> <td>7</td> <td>5</td> <td>19</td> <td>9</td> <td>6</td> <td>10</td> <td>10</td> </tr> <tr> <td>n</td> <td>7</td> <td>5</td> <td>19</td> <td>9</td> <td>6</td> <td>10</td> <td>10</td> </tr> <tr> <td>%S</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>% C</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table> <p>According to the PSSC Coordinator, to date, PSH has trained a total of 1518 direct care staff.</p> <p>A review of documentation (PBS plans, structural and functional assessments, and staff training roster) for nine PBS plans (JA, JL, KM, MLB, FS, DK, GJ, TG, and RJ) found that the staff responsible for implementing all nine plans had been trained. PBS and DCAT team members at PSH continue to receive training from the PSSC Coordinator, CRIPA consultants, and from the PBS team members themselves.</p> <p>Compliance: Substantial.</p>	Staff Training									Nov	Dec	Jan	Feb	Mar	Apr	Mean	N	7	5	19	9	6	10	10	n	7	5	19	9	6	10	10	%S	100	100	100	100	100	100	100	% C	100%	100%	100%	100%	100%	100%	100%
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% C	100%	100%	100%	100%	100%	100%	100%																																											

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		<p>Current recommendation: Continue current practice.</p>																			
F.2.a.ii	<p>the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: According to the By Choice Coordinator, the Central Council has endorsed the By Choice program. Training continues for staff and individuals on By Choice matters. The following table summarizes general staff training on By Choice during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 748 1873 902"> <thead> <tr> <th></th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Number of staff eligible for training</td> <td>2057</td> </tr> <tr> <td>Number of staff trained</td> <td>1933</td> </tr> <tr> <td>Percentage of eligible staff trained</td> <td>94%</td> </tr> </tbody> </table> <p>The following table summarizes WRPT staff training on By Choice Point Allocation during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1052 1873 1206"> <thead> <tr> <th></th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Number of staff eligible for training</td> <td>317</td> </tr> <tr> <td>Number of staff trained</td> <td>269</td> </tr> <tr> <td>Percentage of eligible staff trained</td> <td>85%</td> </tr> </tbody> </table> <p>Using the Fidelity of Implementation By Choice Direct Care Staff Competency and Fidelity Monitoring Form, PSH assessed its compliance based on a mean sample of 4% of the Level of Care staff:</p> <table border="1" data-bbox="991 1390 1873 1427"> <tbody> <tr> <td>1.</td> <td><i>Staff understands the goal of the By Choice system</i></td> <td>100%</td> </tr> </tbody> </table>		Mean	Number of staff eligible for training	2057	Number of staff trained	1933	Percentage of eligible staff trained	94%		Mean	Number of staff eligible for training	317	Number of staff trained	269	Percentage of eligible staff trained	85%	1.	<i>Staff understands the goal of the By Choice system</i>	100%
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1.	<i>Staff understands the goal of the By Choice system</i>	100%																			

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		2.	<i>Staff can state the current point cycle</i>	100%
		3.	<i>Staff can state the procedure for assigning participation points on an individual's point card.</i>	100%
		4.	<i>Staff can state the behavioral criteria, as it appears in the By Choice manual, for determining and assigning individual FP, MP, and NP for the current cycle.</i>	100%
		5.	<i>Staff correctly assigns an appropriate participation level and marks and individuals By Choice</i>	100%
		6.	<i>Staff can locate the current By Choice Manual on their worksite or can correctly identify the location where the By Choice manual can be found.</i>	100%
		7.	<i>Staff can correctly state the difference between a Baseline point card and a Reallocation point card.</i>	100%
		8.	<i>Staff can state when and how By Choice points are reallocated and where the review and reallocation documentation can be found in an individual's WRP.</i>	100%
		9.	<i>Staff can indicate that there is a system for orienting new individuals to the By Choice system.</i>	100%
		10.	<i>Staff is able to state their unit or programs Incentive Store hours of operation.</i>	100%
		11.	<i>Staff can correctly state what the By Choice levels indicate and how they can achieve higher levels.</i>	99%
<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p>				
<p>Other findings: Using the Fidelity of Implementation by Individuals Form, PSH also assessed fidelity of By Choice implementation based on a mean sample of 4% of individuals in the facility:</p>				
		1.	<i>The individual understands the goal of the By Choice system.</i>	79%

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		2.	<i>Individual is holding his/her own Point Card or if not, indicates which staff member is holding it for them.</i>	98%																					
		3.	<i>The individual can state, to the best of his/her ability how they earn points throughout the day.</i>	93%																					
		4.	<i>The individual can state how they spend their By Choice points and what types of items they can purchase with their points.</i>	93%																					
		5.	<i>The individual can state the behavioral criteria for earning an FP, MP, or NP for the current cycle.</i>	72%																					
		6.	<i>Individual can indicate how many points he or she may earn each day.</i>	75%																					
		7.	<i>Individual can correctly state the difference between a Baseline Point card and a Reallocated Point Card.</i>	53%																					
		8.	<i>Individual can correctly state the procedure for reallocating their By Choice points.</i>	56%																					
		9.	<i>The individual is able to state their unit or program's incentive store hours of operation.</i>	89%																					
		10.	<i>Individual is able to state what the By Choice levels indicate and how they can achieve higher levels.</i>	20%																					
		<p>Comparative data indicated maintenance of a compliance rate of at least 90% from the previous review period for items 2-4, and mixed changes in compliance for the remaining items:</p>																							
		<table border="1"> <thead> <tr> <th data-bbox="976 1088 1522 1169"></th> <th data-bbox="1522 1088 1711 1169">Previous period</th> <th data-bbox="1711 1088 1921 1169">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="976 1169 1921 1209">Mean compliance rate</td> <td></td> <td></td> </tr> <tr> <td data-bbox="976 1209 1522 1242">1.</td> <td data-bbox="1522 1209 1711 1242">78%</td> <td data-bbox="1711 1209 1921 1242">79%</td> </tr> <tr> <td data-bbox="976 1242 1522 1274">5.</td> <td data-bbox="1522 1242 1711 1274">78%</td> <td data-bbox="1711 1242 1921 1274">72%</td> </tr> <tr> <td data-bbox="976 1274 1522 1307">6.</td> <td data-bbox="1522 1274 1711 1307">79%</td> <td data-bbox="1711 1274 1921 1307">75%</td> </tr> <tr> <td data-bbox="976 1307 1522 1339">7.</td> <td data-bbox="1522 1307 1711 1339">79%</td> <td data-bbox="1711 1307 1921 1339">53%</td> </tr> <tr> <td data-bbox="976 1339 1522 1396">8.</td> <td data-bbox="1522 1339 1711 1396">55%</td> <td data-bbox="1711 1339 1921 1396">56%</td> </tr> </tbody> </table>				Previous period	Current period	Mean compliance rate			1.	78%	79%	5.	78%	72%	6.	79%	75%	7.	79%	53%	8.	55%	56%
	Previous period	Current period																							
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7.	79%	53%																							
8.	55%	56%																							

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		9.	88%	89%
		10.	22%	20%
		Compliance rate in last month of period		
		1.	64%	92%
		5.	78%	92%
		6.	79%	96%
		7.	51%	81%
		8.	55%	85%
		9.	88%	100%
		10.	22%	67%
		<p>Using the By Choice Monitoring Form: Satisfaction Check, PSH surveyed a mean sample of 13% of the individuals in the facility to evaluate their satisfaction with the By Choice Incentive program:</p>		
			Previous period	Current period
		1.	<i>By Choice motivates me to participate in treatment</i>	70% 70%
		2.	<i>The point system motivates me to improve my behavior</i>	63% 68%
		3.	<i>The point system motivates me to learn new skills</i>	63% 61%
		4.	<i>When staff completes my Point Card, they explain what I did to earn an FP, MP or NP</i>	54% 60%
		5.	<i>My WRPT discusses By Choice with me during my WRPC</i>	57% 63%
		6.	<i>During my WRPC I have input into how my points are allocated on my Point Card</i>	59% 65%
		7.	<i>My WRPT uses By Choice to help me improve my behavior</i>	63% 65%

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		8.	<i>My WRPT uses By Choice to help me learn new skills</i>	65%	66%	
		9.	<i>My unit staff uses By Choice to help me improve my behavior</i>	64%	65%	
		10.	<i>My unit staff uses By Choice to help me learn new skills</i>	59%	64%	
		11.	<i>I like the selection of ITEMS at the Incentive Store</i>	73%	72%	
		12.	<i>I like the selection of ACTIVITIES at the Incentive Store</i>	61%	64%	
		13.	<i>I like the prices of the ITEMS at the Incentive Store</i>	55%	60%	
		14.	<i>I like the price of the ACTIVITIES at the Incentive Store</i>	57%	59%	
		15.	<i>Overall, I am satisfied with the By Choice Incentive system</i>	74%	72%	
		<p>The By Choice Coordinator believes that a quarterly administration of the individual survey may be more appropriate as the current monthly survey is difficult to administer due to the individuals' reluctance associated with the frequency and redundancy of the process.</p> <p>Using the Fidelity of Implementation by the By Choice Staff Form, PSH further assessed fidelity of implementation based on a 100% sample of By Choice staff:</p>				
		1.	<i>The incentive store has regular hours of operation and they are posted in the incentive store(s) and on the units and Malls.</i>	100%		
		2.	<i>The incentive store includes a delivery system that ensures that all individuals have access to incentive items.</i>	100%		
		3.	<i>The incentive store is well stocked with appropriate</i>	100%		

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			<i>items from the incentive list.</i>	
		4.	<i>The incentive store has an inventory control system.</i>	100%
		5.	<i>The incentive store has a system to track and remove outdated food items.</i>	100%
		6.	<i>There is a By Choice Manual located in the incentive store.</i>	100%
		7.	<i>The incentive store staff has completed incentive store training.</i>	100%
		8.	<i>The individuals bring their point cards to the store to make a purchase.</i>	100%
		9.	<i>There is a By Choice Calorie Activity Guide located in the incentive store.</i>	100%
		10.	<i>There is an Alert List in the incentive store for staff reference.</i>	100%
		11.	<i>There is an Alert List in the incentive store for use by store staff.</i>	100%
		<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>This monitor visited three By Choice incentive stores. Some of the stores are small and/or narrow, making it difficult to display items and for individuals to walk through to survey the items. The stores also need a computerized inventory system to ensure accuracy of points and expedite the exchange process.</p> <p>Using the DMH By Choice Implementation Monitoring Forms (Level of Care Staff, Individuals, and By Choice program staff), PSH assessed fidelity of implementation based on average samples of 4% of the Level of Care Staff, 4% of the Individuals, and 100% of the By Choice program staff. The table below is a summary of the data:</p>		

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		<table border="1" data-bbox="993 228 1585 345"> <tr> <td>Level of Care Staff</td> <td>100%</td> </tr> <tr> <td>Individuals</td> <td>73%</td> </tr> <tr> <td>By Choice Program Staff</td> <td>100%</td> </tr> </table> <p>PSH has initiated a collaborative effort among medical, nutritional, psychological, and rehabilitative services to incorporate the By Choice incentive system for individuals with high BMIs.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	Level of Care Staff	100%	Individuals	73%	By Choice Program Staff	100%
Level of Care Staff	100%							
Individuals	73%							
By Choice Program Staff	100%							
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The Chief of Psychology confirmed that he continues to have clinical and administrative authority for the PBS Teams and the By Choice incentive program. However, the Chief has delegated the responsibilities to the Coordinator of the Psychology Specialty Services Committee.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>						

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F.2.c	Each State Hospital shall ensure that:	Compliance: Substantial.																								
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="989 673 1890 1424"> <tr> <td data-bbox="989 673 1087 784">1.</td> <td data-bbox="1087 673 1793 784"><i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i></td> <td data-bbox="1793 673 1890 784">100%</td> </tr> <tr> <td data-bbox="989 784 1087 862">2.</td> <td data-bbox="1087 784 1793 862"><i>The WRPT and the PSST determined the goals of the intervention.</i></td> <td data-bbox="1793 784 1890 862">100%</td> </tr> <tr> <td data-bbox="989 862 1087 940">3.</td> <td data-bbox="1087 862 1793 940"><i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i></td> <td data-bbox="1793 862 1890 940">100%</td> </tr> <tr> <td data-bbox="989 940 1087 1050">4.</td> <td data-bbox="1087 940 1793 1050"><i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i></td> <td data-bbox="1793 940 1890 1050">100%</td> </tr> <tr> <td data-bbox="989 1050 1087 1161">5.</td> <td data-bbox="1087 1050 1793 1161"><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i></td> <td data-bbox="1793 1050 1890 1161">100%</td> </tr> <tr> <td data-bbox="989 1161 1087 1239">6.</td> <td data-bbox="1087 1161 1793 1239"><i>A functional assessment interview was completed for the structural assessment.</i></td> <td data-bbox="1793 1161 1890 1239">100%</td> </tr> <tr> <td data-bbox="989 1239 1087 1317">7.</td> <td data-bbox="1087 1239 1793 1317"><i>Direct observations of the challenging behavior were undertaken, as applicable</i></td> <td data-bbox="1793 1239 1890 1317">100%</td> </tr> <tr> <td data-bbox="989 1317 1087 1424">8.</td> <td data-bbox="1087 1317 1793 1424"><i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i></td> <td data-bbox="1793 1317 1890 1424">100%</td> </tr> </table>	1.	<i>The individual's WRPT and the PSST are involved in the assessment process during the development of the BG or PBS plan.</i>	100%	2.	<i>The WRPT and the PSST determined the goals of the intervention.</i>	100%	3.	<i>At least one specific behavior of concern was defined in clear, observable and measurable terms</i>	100%	4.	<i>Baseline of maladaptive behavior was established in terms of objective measures (e.g., rate, frequency, duration, intensity and severity).</i>	100%	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events and consequences.</i>	100%	6.	<i>A functional assessment interview was completed for the structural assessment.</i>	100%	7.	<i>Direct observations of the challenging behavior were undertaken, as applicable</i>	100%	8.	<i>Additional structural assessments (e.g., ecological, sleep, medication effects, Mall attendance) were completed. [This item is N/A for BGs.]</i>	100%
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		<table border="1"> <tr> <td data-bbox="989 188 1087 228">9.</td> <td data-bbox="1087 188 1793 228"><i>A functional assessment rating scale was completed.</i></td> <td data-bbox="1793 188 1894 228">100%</td> </tr> <tr> <td data-bbox="989 228 1087 415">10.</td> <td data-bbox="1087 228 1793 415"><i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i></td> <td data-bbox="1793 228 1894 415">100%</td> </tr> <tr> <td data-bbox="989 415 1087 492">11.</td> <td data-bbox="1087 415 1793 492"><i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i></td> <td data-bbox="1793 415 1894 492">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of nine PBS plans (DK, FS, GJ, JA, JL, KM, MLB, RJ and TG) found that all nine plans had been developed and implemented based on data derived from structural and functional assessments.</p> <p>To further enhance practice during the maintenance phase, the facility could conduct functional analysis during the assessment phase of the structural and functional assessments. Variables (one or more in a sequential fashion) can be manipulated during the assessment phase in the setting/location or time/day to confirm or refine the hypothesis. This can be ongoing during the time it takes for the assessments to be completed, reports to be completed, and plans developed.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	9.	<i>A functional assessment rating scale was completed.</i>	100%	10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i>	100%	11.	<i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i>	100%
9.	<i>A functional assessment rating scale was completed.</i>	100%									
10.	<i>Additional functional assessment interviews were conducted with people (e.g., individual, level of care staff, clinical staff, and mall staff) who often interact with the individual within different settings and activities. [This item is N/A for BGs.]</i>	100%									
11.	<i>Patterns of challenging behavior were recognized based on the structural and functional assessments.</i>	100%									
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>									

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		<p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 375 1887 453"> <tr> <td data-bbox="991 375 1087 453">12.</td> <td data-bbox="1087 375 1793 453"><i>Testable data-based hypotheses of the challenging behavior were developed.</i></td> <td data-bbox="1793 375 1887 453">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of nine PBS plans (DK, FS, GJ, JA, JL, KM, MLB, RJ and TG) found that the hypotheses in all nine plans were based on structural and functional assessments and aligned with findings from the structural/functional assessments.</p> <p>To further improve the assessments during the maintenance phase, the facility could:</p> <ol style="list-style-type: none"> 1. Hypothesize why the target behavior might be infrequent or non-occurring in certain settings/occasions; 2. Ensure that hypotheses are specific and detailed. For example, it is not adequate to simply state "patient is disruptive to escape task/avoid task/obtain tangibles." It is useful to state what the individual is escaping from or wanting, and associated information (for example, patient avoids tasks asked of him/her by certain staff or gender, at certain time of day; at certain difficulty level, etc); 3. List separately the operational definition, hypothesized function, and predictive behaviors for each target behavior. Do not lump them all under one; and 4. State clearly the reinforcers and their schedule for each target behavior. 	12.	<i>Testable data-based hypotheses of the challenging behavior were developed.</i>	100%
12.	<i>Testable data-based hypotheses of the challenging behavior were developed.</i>	100%			

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 672 1887 786"> <tr> <td>5.</td> <td><i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events, and consequences.</i></td> <td>100%</td> </tr> </table> <p>A review of nine PBS plans (DK, FS, GJ, JA, JL, KM, MLB, RJ and TG) found that all nine had documented previous behavioral interventions and their effects, as part of the documentation review during the structural and functional assessments.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events, and consequences.</i>	100%
5.	<i>Pertinent records of the individual's challenging behavior were reviewed for antecedents, triggering events, and consequences.</i>	100%			
F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the</p>			

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		<p>review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 264 1887 378"> <tr> <td data-bbox="993 264 1087 378">17.</td> <td data-bbox="1087 264 1793 378"><i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs</i></td> <td data-bbox="1793 264 1887 378">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 14 PBS and BG intervention plans (AB, ALA, AS, DF, DG, DK, FS, GJ, JA, JC, JL, JP, KA and SA) found that all 14 behavioral interventions were based on a positive behavioral supports model without any use of aversive or punishment contingencies.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs</i>	100%
17.	<i>Reactive strategies, excluding any use of aversive or punishment contingencies for the staff to use when the challenging behavioral occurs</i>	100%			
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 1193 1887 1271"> <tr> <td data-bbox="993 1193 1087 1271">9.</td> <td data-bbox="1087 1193 1793 1271"><i>Behavioral interventions are consistently implemented across all settings, including school settings</i></td> <td data-bbox="1793 1193 1887 1271">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p>	9.	<i>Behavioral interventions are consistently implemented across all settings, including school settings</i>	100%
9.	<i>Behavioral interventions are consistently implemented across all settings, including school settings</i>	100%			

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		<p>This monitor's review of fidelity/integrity check for the PBS plans and behavior guidelines of nine individuals (DK, FS, GJ, JA, JL, KM, MLB, RJ and TG) found that PSH had conducted fidelity checks on all nine PBS plans and PBS-driven behavior guidelines.</p> <p>To further enhance practice during the maintenance phase, the facility could assess factors including the process and the "idiosyncratic variables" besides the implementation of the components of the behavioral plan when assessing fidelity (for example, the posture of staff when de-escalating, the tone of the voice, distance/space from the individual, latency of the instructions/reinforcement, etc.).</p> <p>Current recommendation: Continue to monitor this requirement.</p>																																																								
F.2.c.vi	<p>triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or psychiatric PRN and Stat medication for behavior control;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: The table below showing the type of trigger, the number of individuals meeting threshold for each month of this review period, and the percentage of referrals made to the PSSC (%C) for each of the triggers is a summary of the facility's data:</p> <table border="1" data-bbox="991 1154 1906 1421"> <thead> <tr> <th colspan="8">DMH Psychology Services Monitoring Form</th> </tr> <tr> <th>2008/2009</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>Restraint</td> <td>3</td> <td>2</td> <td>11</td> <td>8</td> <td>8</td> <td>5</td> <td>6.1</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Seclusion</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>%C</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1:1</td> <td>51</td> <td>39</td> <td>84</td> <td>83</td> <td>87</td> <td>83</td> <td>71.6</td> </tr> </tbody> </table>	DMH Psychology Services Monitoring Form								2008/2009	Nov	Dec	Jan	Feb	Mar	Apr	Mean	Restraint	3	2	11	8	8	5	6.1	%C	100	100	100	100	100	100	100	Seclusion	0	0	0	0	0	0	0	%C	-	-	-	-	-	-	-	1:1	51	39	84	83	87	83	71.6
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		<table border="1" data-bbox="991 191 1908 386"> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Aggression to others</td> <td>42</td> <td>41</td> <td>65</td> <td>60</td> <td>64</td> <td>54</td> <td>54.3</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> <tr> <td>Aggression to self</td> <td>4</td> <td>5</td> <td>7</td> <td>5</td> <td>4</td> <td>6</td> <td>5.16</td> </tr> <tr> <td>%C</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> <td>100</td> </tr> </table> <p>Current recommendation: Continue to monitor this requirement.</p>	%C	100	100	100	100	100	100	100	Aggression to others	42	41	65	60	64	54	54.3	%C	100	100	100	100	100	100	100	Aggression to self	4	5	7	5	4	6	5.16	%C	100	100	100	100	100	100	100
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%C	100	100	100	100	100	100	100																																			
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy:	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 902 1890 1016"> <tr> <td data-bbox="991 902 1087 1016">11.</td> <td data-bbox="1087 902 1793 1016"><i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i></td> <td data-bbox="1793 902 1890 1016">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of nine PBS plans (DK, FS, GJ, JA, JL, KM, MLB, RJ and TG) found that all nine assessments had progress notes and/or entries in the structural and functional assessment reports on interdisciplinary collaboration.</p> <p>To further enhance practice during the maintenance phase, the facility could:</p>	11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%																																					
11.	<i>Positive Behavior Support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy.</i>	100%																																								

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		<ol style="list-style-type: none"> 1. Include non-social variables (for example mental illness, physical health, respondent behaviors) when they are suspected to contribute/influence the target behaviors as part of the structural and functional assessments; 2. Identify factors and analyze data obtained from settings in which the target behaviors do not or are least likely to occur; and 3. Conduct second-order analysis to refine functions derived from indirect assessments. <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.viii	<p>all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1042 1887 1156"> <tr> <td data-bbox="991 1042 1087 1156">19.</td> <td data-bbox="1087 1042 1793 1156"><i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i></td> <td data-bbox="1793 1042 1887 1156">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals with PBS plans or PBS assessments (AB, ALA, AS, DF, DG, DK, FS, GJ, JA, JC, JL, JP, KA and SA) found that all 14 of the WRPs had properly discussed the PBS plans</p>	19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%
19.	<i>The BG or PBS plan, as applicable, is specified in the Present Status Section of the individual's WRP and the Objective and Intervention sections</i>	100%			

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		<p>in the Present Status section of the individual's WRP, with objectives and interventions in the relevant sections.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.ix	<p>all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans and behavior guidelines developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 784 1890 862"> <tr> <td>24.</td> <td><i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 14 individuals with PBS plans (AB, ALA, AS, DF, DG, DK, FS, GJ, JA, JC, JL, JP, KA and SA) found that the plans were updated as indicated and reported at least quarterly in the Present Status section of the individual's WRP in all 14 cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%
24.	<i>The WRPT Psychologist discusses the individual's monthly outcome data during the WRPC.</i>	100%			
F.2.c.x	<p>all staff has received competency-based training on implementing the specific behavioral interventions for which they are</p>	<p>Current findings on previous recommendation:</p>			

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	<p>responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.</p>	<p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of behavior guidelines developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 485 1887 599"> <tr> <td data-bbox="991 485 1087 599">20.</td> <td data-bbox="1087 485 1793 599"><i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i></td> <td data-bbox="1793 485 1887 599">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of PBS plans developed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 894 1887 971"> <tr> <td data-bbox="991 894 1087 971">21.</td> <td data-bbox="1087 894 1793 971"><i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i></td> <td data-bbox="1793 894 1887 971">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of nine PBS plans and related assessment and staff training data (DK, FS, GJ, JA, JL, KM, MLB, RJ and TG) found that the staff responsible for implementing the PBS plans had been trained to competency in all nine plans.</p> <p>Unit staff interviewed by this monitor confirmed that they had received training on PBS/BG plans from the PBS teams. All staff interviewed were able to review/demonstrate the components of the PBS plan/BG</p>	20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%	21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%
20.	<i>The WRP psychologist ensures that the individual's enduring staff (e.g. unit and mall) is trained on the BG plan.</i>	100%						
21.	<i>The PSST ensures that the individual's enduring staff (e.g. unit and mall) is trained on the PBS plan.</i>	100%						

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		<p>implemented for the individuals under their care. Hard copies of the PBS plans were filed at the nursing stations and available to this monitor during the unit visits.</p> <p>Current recommendation: Continue to monitor this requirement.</p>									
F.2.c.xi	<p>all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: The table below showing the percentage of team members whose primary responsibility is the provision of behavioral interventions (15.a.i), the percentage of PBS team members who facilitate at least one Mall group per week (15.a.ii), and the percentage of PBS team members who, when engaged in overtime work, are assigned to PBS-related duties (15.b) is a summary of the facility's data.</p> <table border="1" data-bbox="991 932 1892 1195"> <tr> <td data-bbox="991 932 1094 1008">15.a.i</td> <td data-bbox="1094 932 1780 1008"><i>All PBS team members are primarily responsible for the provision of behavioral interventions</i></td> <td data-bbox="1780 932 1892 1008">100%</td> </tr> <tr> <td data-bbox="991 1008 1094 1084">15.a.ii</td> <td data-bbox="1094 1008 1780 1084"><i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i></td> <td data-bbox="1780 1008 1892 1084">100%</td> </tr> <tr> <td data-bbox="991 1084 1094 1195">15.b</td> <td data-bbox="1094 1084 1780 1195"><i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i></td> <td data-bbox="1780 1084 1892 1195">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>PBS team members informed this monitor that there is no conflict or barrier to their primary role to provide PBS/behavioral intervention</p>	15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%	15.a.ii	<i>All PBS team members facilitate one PSR mall group weekly during their assigned work hours</i>	100%	15.b	<i>If PBS team members are required to do mandatory overtime on state holidays, they are assigned to their usual PBS duties</i>	100%
15.a.i	<i>All PBS team members are primarily responsible for the provision of behavioral interventions</i>	100%									
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		<p>services. When they had to work overtime, they were assigned to their usual PBS duties.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.2.c.xii	<p>the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH By Choice Chart Audit Form, PSH assessed its compliance based on an average sample of 11% of the individuals at PSH during this review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 784 1887 860"> <tr> <td data-bbox="991 784 1087 860">16.</td> <td data-bbox="1087 784 1793 860"><i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i></td> <td data-bbox="1793 784 1887 860">95%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of nine individuals found that seven of the WRPs in the charts reported the By Choice point allocation in the Present Status section of the individual's case formulation and updated the information in the subsequent WRPs, meeting full compliance (CK, GM, JH, JL, JS, MB and SC). The remaining two WRPs (JLO and SCW) met partial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	16.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i>	95%
16.	<i>The By Choice point allocation is updated monthly in the individual's Wellness and Recovery Plan</i>	95%			

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<p>F.2.d</p>	<p>Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral supports.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Ensure full staffing of the DCAT.</p> <p>Findings: PSH has one Developmental and Cognitive Assessment Team (DCAT). The facility has identified a candidate for the previously vacant nursing member position. The DCAT still lacks a data analyst; a graduate student is assisting with PBS and DCAT data analysis. The DCAT has an open caseload of 61 individuals, compared to 49 at the time of the last review.</p> <p>Recommendation 2, December 2009: Provide data confirming that the DCAT is providing services to all individuals in need of its services.</p> <p>Findings: Staff interview and documentation review found that the DCAT has increased its service to individuals, staff consultation, and Mall groups during this review period. The DCAT is actively involved in the RISE program (cognitive remediation Mall group). The DCAT has served 61 individuals during this review period through consultation with WRPTs, development and implementation of behavioral intervention plans, and facilitation of cognitive remediation groups.</p> <p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure full staffing of the DCAT. 2. Provide data confirming that the DCAT is providing services to all individuals in need of its services.
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<p>F.2.e</p>	<p>Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Staff interviews and documentation review found that the PSSC has continued to conduct joint meetings with the ETRC. The meetings were held regularly and the attendance rate of its core members was high. The PSSC reviewed 130 cases and opened 90 of them for assessment and services during this review period.</p> <p>Staff interviews and documentation review confirmed that the PSSC reviews all trigger referrals for appropriateness of behavioral assessments or consultations.</p> <p>A review of the records of seven individuals triggering during this review period (DLR, EG, GB, HDM, KDP, RPJ and VF) found that all seven had been reviewed by the PSSC. Following the PSSC review, behavior guidelines had been developed and implemented for three individuals (DLR, GB and KDP); PBS plans were developed and implemented for two individuals (RPJ and VF); and the PSSC determined that triggers for two individuals (EG and HDM) were medically/psychiatrically driven and that the individuals would not benefit from behavioral assessment at this time. The monitor's findings are in agreement with the facility's data presented in the table in F.2.C.vi.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
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F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Psychology Services Monitoring Form, PSH assessed its compliance based on a 100% sample of referrals received each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 560 1915 974"> <thead> <tr> <th></th> <th>2009/2010</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> <th>Apr</th> <th>Mean</th> </tr> </thead> <tbody> <tr> <td>18.a. i</td> <td><i>Number of neuropsychological assessments due for completion in the review month</i></td> <td>11</td> <td>9</td> <td>19</td> <td>11</td> <td>9</td> <td>21</td> <td>13.3</td> </tr> <tr> <td>18.a. ii</td> <td><i>Of those in 18.a.i, number completed</i></td> <td>3</td> <td>0</td> <td>9</td> <td>2</td> <td>0</td> <td>9</td> <td>2.8</td> </tr> <tr> <td>18.a. iii</td> <td><i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i></td> <td colspan="6"></td> <td>121</td> </tr> </tbody> </table> <p>Neuropsychologists at PSH have continued to assess and treat individuals referred for neuropsychological services. As the table above indicates, 23 of the 80 referrals due were completed during this review period. It took an average of 121 days for completion from the day of referral, but the assessments were completed within 30 days of assignment to a clinician.</p> <p>Staff interviews and documentation review found that a number of factors contributed to the slow turnaround of referrals. Staffing shortage and additional tasks during this review period contributed to the delay in completing referrals in a timely manner. One staff member</p>		2009/2010	Nov	Dec	Jan	Feb	Mar	Apr	Mean	18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	11	9	19	11	9	21	13.3	18.a. ii	<i>Of those in 18.a.i, number completed</i>	3	0	9	2	0	9	2.8	18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							121
	2009/2010	Nov	Dec	Jan	Feb	Mar	Apr	Mean																														
18.a. i	<i>Number of neuropsychological assessments due for completion in the review month</i>	11	9	19	11	9	21	13.3																														
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18.a. iii	<i>Average time taken from referral to completion for all neuropsychological assessments during the current evaluation period</i>							121																														

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		<p>had been on maternity leave since July 2009, and another staff member had been assigned to assist with other activities. In addition, the neuropsychology service had been asked to support the development and implementation of seizure protocols, and assessment and services for 44 of 65 individuals needing seizure assessment and services. According to the Chief of Psychology, the two staff members have returned to active duty with the department and the additional support provided to other functions has been completed, so the neuropsychology service is expected to be back on track to complete neuropsychology referrals in a more timely fashion. The service plans to continue to:</p> <ol style="list-style-type: none"> 1. Work with Senior Psychologists to improve awareness of the need for NCS referral at the WRPT level; 2. Continue to provide training to psychologists and psychiatrists on the need and method for referring to the NCS; and 3. Continue to work on efficiency standards (e.g., provide consultation to units in lieu of comprehensive batteries when appropriate). <p>Compliance: Partial.</p> <p>Current recommendation: Continue to monitor this requirement and implementation of the plan to reduce the turnaround time for completion of neuropsychological assessments.</p>
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Psychologists at PSH continue to have the authority to write orders for</p>

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		<p>the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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3. Nursing Services		
	<p>Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.</p>	<p>Methodology:</p> <p><u>Interviewed:</u> Lidia Lau, RN, ACNS</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH's progress report and data 2. PSH's training rosters 3. Medication Variance Reports for MAR and Narcotic Log blanks 4. Medication Variance Reporting Process Structure 5. Medication Administration Monitoring audit for medication observation 6. Medical records for the following 65 individuals: AJV, AV, BJN, BM, BSH, CDC, CDT, CH, CMJ, DAB, DAF, DB, DGA, DJ, DLJ, EAL, EH, FGC, FJ, FL, GH, GJD, GO, HCC, HDM, HLE, HMP, JAM, JCH, JFL, JG, JL, JM, JMG, JPL, LF, LS, MAK, MGS, MH, ML, MLR, MLS, MLV, MRH, MS, NJG, PC, RAD, RAF, RAS, RC, RJ, RPJ, RTH, SA, SMM, SWK, TBF, TEM, TM, VSC, WAH, WI and WWD <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. WRPC (Program I, unit U05) for quarterly review of SAN 2. WRPC (Program VI, unit 71) for 14-day review of TW 3. WRPC (Program VI, unit EBO2) for 14-day review of DC 4. Observation of shift report on unit EBO2 5. Medication administration on Unit 74
F.3.a	<p>Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to</p>	<p>Compliance: Substantial.</p>

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	ensure:							
F.3.a.i	safe administration of PRN medications and Stat medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 638 1887 675"> <tr> <td data-bbox="993 638 1087 675">1.</td> <td data-bbox="1087 638 1793 675"><i>Safe administration of PRN medications</i></td> <td data-bbox="1793 638 1887 675">94%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 24% mean sample of Stat medications administered each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 1011 1887 1049"> <tr> <td data-bbox="993 1011 1087 1049">2.</td> <td data-bbox="1087 1011 1793 1049"><i>Safe administration of Stat medications</i></td> <td data-bbox="1793 1011 1887 1049">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 152 PRN and Stat orders (107 PRN and 45 Stat) for 54 individuals (AJV, AV, BJN, BM, BSH, CDC, CDT, CH, CMJ, DAB, DAF, DB, DGA, EAL, EH, FGC, FJ, FL, GH, GJD, HCC, HDM, HLE, HMP, JAM, JCH, JFL, JM, JPL, LF, LS, MAK, MGS, MH, ML, MLR, MLS, MLV, MRH, NJG, PC, RAD, RAS, RPJ, RTH, SA, SMM, SWK, TBF, TEM, VSC, WAH, WI and WWD) found that all included specific individual behaviors. In addition,</p>	1.	<i>Safe administration of PRN medications</i>	94%	2.	<i>Safe administration of Stat medications</i>	98%
1.	<i>Safe administration of PRN medications</i>	94%						
2.	<i>Safe administration of Stat medications</i>	98%						

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		<p>all 152 notes reviewed included the dosages and routes of the PRN/Stat medications and the sites of the injections were documented in 151 notes.</p> <p>Current recommendation: Continue current practice.</p>			
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to implement strategies to increase compliance with this requirement. • Continue to monitor this requirement. <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 857 1887 1008"> <tr> <td data-bbox="993 857 1087 1008">3.</td> <td data-bbox="1087 857 1793 1008"><i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1793 857 1887 1008">97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 107 incidents of PRN medications for 36 individuals (AJV, AV, BJN, BSH, CDC, CDT, CH, DAF, DGA, EAL, EH, FJ, FL, GH, GJD, HCC, HDM, HLE, JPL, LF, LS, MAK, MGS, MH, ML, MRH, NJG, PC, RAS, RTH, SA, SMM, TBF, TEM, WAH and WWD) found adequate documentation in the IDNs of the circumstances requiring the PRN in 105 incidents.</p>	3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	97%
3.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the PRN medication administration, which includes the circumstances/behavior requiring the medication.</i>	97%			

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		<p>Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 24% mean sample of Stat medications administered each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="993 378 1890 527"> <tr> <td data-bbox="993 378 1087 527">4.</td> <td data-bbox="1087 378 1795 527"><i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i></td> <td data-bbox="1795 378 1890 527">96%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 45 incidents of Stat medications for 35 individuals (AJV, AV, BJN, BM, BSH, CDT, CH, CMJ, DAB, DB, DGA, EAL, EH, FGC, FL, HMP, JAM, JCH, JFL, JM, LF, MLR, MLS, MLV, MRH, PC, RAD, RAS, RPJ, SA, SWK, VSC, WAH, WI and WWD) found adequate documentation in the IDNs of the circumstances requiring the Stat in 44 incidents.</p> <p>Current recommendation: Continue current practice.</p>	4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	96%
4.	<i>There is documentation in the Interdisciplinary Note of the individual prior to the Stat medication administration, which includes the circumstances/behavior requiring the medication.</i>	96%			
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to implement strategies to increase compliance with this requirement. • Continue to monitor this requirement. <p>Findings: Using the DMH Nursing Services Monitoring PRN Audit, PSH assessed its compliance based on a 20% mean sample of PRNs administered each month during the review period (November 2009-April 2010):</p>			

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		<table border="1" data-bbox="991 228 1887 342"> <tr> <td data-bbox="991 228 1087 342">5.</td> <td data-bbox="1087 228 1793 342"><i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i></td> <td data-bbox="1793 228 1887 342">92%</td> </tr> </table> <p data-bbox="991 386 1887 451">Comparative data indicated improvement in compliance from 83% in the previous review period.</p> <p data-bbox="991 495 1898 673">A review of 107 incidents of PRN medications for 36 individuals (AJV, AV, BJN, BSH, CDC, CDT, CH, DAF, DGA, EAL, EH, FJ, FL, GH, GJD, HCC, HDM, HLE, JPL, LF, LS, MAK, MGS, MH, ML, MRH, NJG, PC, RAS, RTH, SA, SMM, TBF, TEM, WAH and WWD) found a timely, comprehensive assessment in the IDNs of the individual's response in 103 incidents.</p> <p data-bbox="991 717 1898 857">Using the DMH Nursing Services Monitoring Stat Audit, PSH assessed its compliance based on a 24% mean sample of Stat medications administered each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 898 1887 1011"> <tr> <td data-bbox="991 898 1087 1011">6.</td> <td data-bbox="1087 898 1793 1011"><i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i></td> <td data-bbox="1793 898 1887 1011">90%</td> </tr> </table> <p data-bbox="991 1055 1887 1120">Comparative data indicated improvement in compliance from 83% in the previous review period.</p> <p data-bbox="991 1164 1898 1343">A review of 45 incidents of Stat medications for 35 individuals (AJV, AV, BJN, BM, BSH, CDT, CH, CMJ, DAB, DB, DGA, EAL, EH, FGC, FL, HMP, JAM, JCH, JFL, JM, LF, MLR, MLS, MLV, MRH, PC, RAD, RAS, RPJ, SA, SWK, VSC, WAH, WI and WWD) found a timely, comprehensive assessment in the IDNs of the individual's response in 43 incidents.</p>	5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	92%	6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	90%
5.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the PRN medication within one hour of administration.</i>	92%						
6.	<i>There is documentation in the Interdisciplinary Note of the individual's response to the Stat medication within one hour of administration.</i>	90%						

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		<p>Current recommendation: Continue current practice.</p>
<p>F.3.b</p>	<p>Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: PSH's process for MVRs continues to include the following steps:</p> <ul style="list-style-type: none"> • The NCs, Unit Supervisors, and SRN conduct random monitoring of the Medication and Treatment Administration Records and the Controlled Drug Count Record. If documentation issues such as missing initials or signatures or pre-signed MTRs are found, the medication nurse generates a Medication Variance Report and the program NC is notified. • The US and NC review copies of the unit nightly audits. • The Clinical Management Team reviews the MVRs, identifying trends. • Reports are provided to the US/NC and specific variance issues are addressed on a unit level for all missing initials/signatures to prevent recurrences. <p>A review of a random sample of 50 MVRs found that PSH had MVRs for the missing initials and signatures on the MARs and Narcotic Logs that were reported. In addition, a review of a medication variance for one individual (JMG) found that the variance was quickly discovered and reported to the physician. The individual was appropriately assessed at the facility and sent to the community hospital for further evaluation and assessment. Staff involved were provided retraining and additional medication administration observations. The MVR was timely initiated; however, the date of the clinical review documented on the MVR was noted not to be within the required three business days.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that clinical reviews for MVRs are timely completed. 2. Continue to monitor this requirement.
F.3.c	<p>Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: No nursing care plans or nursing diagnoses other than those in the WRPs were found during this review. See C.2.1 for findings addressing WRP interventions.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.3.d	<p>All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Nursing Staff Familiarity Monitoring Audit, PSH assessed its compliance based on an average sample of 56% of the nursing staff:</p>

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		<table border="1"> <tr> <td data-bbox="989 188 1087 342">8.</td> <td data-bbox="1087 188 1793 342"><i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i></td> <td data-bbox="1793 188 1892 342">96%</td> </tr> </table>	8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	96%	
8.	<i>Given a focus and objective(s) for an individual on the nursing staff's caseload, the nursing staff is able to discuss the individual's therapeutic milieu interventions as described in the WRP.</i>	96%				
<p>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.</p>		<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>In three WRPCs observed by this monitor, all team members were very familiar with the individuals' WRP goals and interventions. Also, in conversation with unit staff, all were familiar with the goals and interventions of the individuals on their units.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p> <p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to implement strategies to increase compliance with this requirement. • Continue to monitor this requirement. <p>Findings: Using the DMH Medical Transfer Audit, PSH assessed its compliance based on a 100% sample of individuals transferred to community hospitals each month during the review period (November 2009-April 2010):</p>	<table border="1"> <tr> <td data-bbox="989 1341 1087 1416">1.</td> <td data-bbox="1087 1341 1793 1416"><i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and</i></td> <td data-bbox="1793 1341 1892 1416">97%</td> </tr> </table>	1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and</i>	97%
1.	<i>There is an appropriate documentation by the nurse that identifies the symptoms of concern and</i>	97%				

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		<table border="1"> <tr> <td data-bbox="989 190 1087 228"></td> <td data-bbox="1087 190 1793 228"><i>notification of the physician.</i></td> <td data-bbox="1793 190 1894 228"></td> </tr> <tr> <td data-bbox="989 228 1087 342">7.</td> <td data-bbox="1087 228 1793 342"><i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></td> <td data-bbox="1793 228 1894 342">90%</td> </tr> </table>		<i>notification of the physician.</i>		7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	90%
	<i>notification of the physician.</i>							
7.	<i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i>	90%						
<p>Comparative data indicated that PSH maintained a compliance rate of at least 90% for item 1; the compliance rate for item 7 improved from 72% in the previous review period.</p> <p>A review of the records of 11 individuals who were transferred to a community hospital/emergency room (DJ, DLJ, GO, JG, JL, MS, RAF, RC, RJ, SA and TM) found the following problematic issues:</p> <ul style="list-style-type: none"> ▪ Lack of documentation regarding the status and appropriate assessment of the individual at the time of the onset of the symptoms; ▪ Lack of documentation regarding an assessment of the individual's status at the time of transfer to hospital or emergency room; ▪ Incomplete Change of Status forms in records; ▪ Discrepancies in description of seizure activity; ▪ Inconsistent completion of seizure records; ▪ Lack of a complete nursing assessment upon return to the facility; ▪ Inadequate assessment of responsiveness following seizure activity; ▪ The lack of adequate descriptions of the site of complaints for pain; ▪ The lack of neurological checks and mental status documented for individuals with a significant change in mental status; ▪ Illegible progress notes, signatures and titles; ▪ The lack of assessment of bowel sounds, and abdomen for individuals with constipation; ▪ The inconsistent use of the Change of Status forms; and ▪ Duplication of documentation in progress notes and the use of the Change of Status form. 								

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		<p>These findings do not comport with PSH's data. In discussions with Nursing, it was reported that Nursing will be auditing the nursing section of change in status to ensure that the nursing assessments and documentation are being adequately reviewed for quality.</p> <p>Using the DMH Nursing Services Audit, PSH assessed its compliance based on a 84% sample of Change of Shift Reports observed during in the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 522 1887 636"> <tr> <td data-bbox="991 522 1087 636">10.</td> <td data-bbox="1087 522 1793 636"><i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i></td> <td data-bbox="1793 522 1887 636">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>Observation of shift report on unit EB02 found that PSH has continued to make progress in providing clinically relevant information to the on-coming shift.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that audits regarding nursing documentation for change in status address the quality and clinical appropriateness of the documentation. 2. Continue to monitor this requirement. 	10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	100%
10.	<i>Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.</i>	100%			
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	<p>Compliance: Partial, due to documentation issue regarding PRN and Stat medications on the medication administration records (See F.3.f.iv).</p>			

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F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 58% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="991 561 1887 638"> <tr> <td data-bbox="991 561 1087 638">11.</td> <td data-bbox="1087 561 1793 638"><i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i></td> <td data-bbox="1793 561 1887 638">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>In observations of medication administration on Unit 74, the medication nurse demonstrated the appropriate process for administering medication and had good interaction with the individuals receiving medications. Medication education had clearly been provided since all individuals observed were able to list the medications they were taking as well as the side effects of the medications. Also, the facility nurse observing the medication administration provided appropriate feedback and correction when appropriate.</p> <p>Current recommendation: Continue current practice.</p>	11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	99%
11.	<i>Nursing staff are knowledgeable regarding each individual's prescribed medications.</i>	99%			
F.3.f.ii	education is provided to individuals during medication administration;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p>			

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		<p>Findings: Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 58% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 378 1892 453"> <tr> <td data-bbox="993 378 1087 453">12.</td> <td data-bbox="1087 378 1795 453"><i>Education is provided to individuals during medication administration.</i></td> <td data-bbox="1795 378 1892 453">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See F.3.f.i for review findings.</p> <p>Current recommendation: Continue current practice.</p>	12.	<i>Education is provided to individuals during medication administration.</i>	99%
12.	<i>Education is provided to individuals during medication administration.</i>	99%			
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 58% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 1157 1892 1232"> <tr> <td data-bbox="993 1157 1087 1232">13.</td> <td data-bbox="1087 1157 1795 1232"><i>Nursing Staff are following the appropriate medication administration protocol.</i></td> <td data-bbox="1795 1157 1892 1232">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See F.3.f.i for review findings.</p>	13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	100%
13.	<i>Nursing Staff are following the appropriate medication administration protocol.</i>	100%			

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		<p>Current recommendation: Continue current practice.</p>			
F.3.f.iv	<p>medication administration is documented in accordance with the appropriate medication administration protocol.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medication Administration Monitoring Audit, PSH assessed its compliance based on an average sample of 58% of level of care nursing staff who are licensed and medication-certified:</p> <table border="1" data-bbox="993 711 1890 824"> <tr> <td data-bbox="993 711 1087 824">14.</td> <td data-bbox="1087 711 1793 824"><i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i></td> <td data-bbox="1793 711 1890 824">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>While observing medication administration on unit 74, this reviewer noted that the time a PRN was given was not included on the Medication Administration Record. The medication nurse had to find this information in the progress notes in the medical record in order to determine if the individual could have the requested PRN. In discussions with Nursing, the facility reported that it had stopped documenting the time a PRN or Stat medication was given on the back of the MAR and was only documenting this information in the progress notes. Nursing needs to document the medication, dosage, route and time administered for PRNs and Stat medications on the medication administration record according to generally accepted standards of practice. Lidia Lau, RN, ACNS verified that the facility's policy regarding medication</p>	14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	100%
14.	<i>Medication administration is documented in accordance with the appropriate medication administration protocol.</i>	100%			

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		<p>documentation does indicate that the time a PRN or Stat medication is administered is to be documented on the medication administration record.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide retraining to staff addressing the need to document the medication, dosage, route and time administered for PRNs and Stat medications on the medication administration record. 2. Ensure that all policies/procedures addressing medication administration and documentation are in alignment with this practice. 3. Continue to monitor this requirement.
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement in the event this issue arises.</p> <p>Findings: There were no bed-bound individuals at PSH during this review period.</p> <p>Compliance: Not applicable.</p> <p>Current recommendations: None.</p>
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	<p>Compliance: Substantial.</p>
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side	<p>Current findings on previous recommendation:</p>

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	effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	<p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Training rosters verified that 10 newly hired RNs and 13 PTs completed and passed the Mental Health Nursing Class, the Therapeutic Strategy Interventions (TSI) Training, PBS, and the Principles of Medication Training.</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: See F.3.h.i.</p> <p>Findings: See F.3.h.i</p> <p>Current recommendation: Continue current practice.</p>
F.3.h.iii	positive behavior support principles.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: See F.3.h.i.</p> <p>Findings: See F.3.h.i</p> <p>Current recommendation: Continue current practice.</p>

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F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: PSH's training rosters verified that 100% of the unit medication room staff has successfully completed competency-based training on the completion of the MTR and the controlled medication log.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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4. Rehabilitation Therapy Services		
	<p>Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Chris Keierleber, Senior Rehabilitation Therapist 2. Greg Siples, Director of Rehabilitation Therapy Services 3. Jacqueline Doss-Haynes, Senior Rehabilitation Therapist 4. Michael Gomes, Senior Rehabilitation Therapist 5. Renata Geyer, Senior Rehabilitation Therapist 6. Sarah Gutierrez, Acting Senior Rehabilitation Therapist 7. Stan Hydinger, Senior Rehabilitation Therapist <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. F.4 audit data for November 2009-April 2010 2. PSH Mall Course Schedule for Rehabilitation Therapy PSR Mall groups for week of review 3. Records of the following 19 individuals participating in PSR Mall groups: AEK, ALG, DAB, EBF, GCD, JLC, KAM, KDE, KHP, KR, LAB, LDB, LET, LMM, MC, OB, ODH, PP and REP 4. List of individuals who received direct physical therapy services from November 2009-April 2010 5. List of individuals who received direct speech therapy services from November 2009-April 2010 6. List of individuals who received direct occupational therapy services from November 2009-April 2010 7. Records of the following 17 individuals who received direct physical, occupational, and speech therapy services from November 2009-April 2010: AKA, AMH, BR, CH, CMT, DWH, GD, JAS, JHM, JLS, JM, MRB, PA, RH, RRA, TM and WMM 8. List of individuals with a 24-Hour Rehabilitation Support Plan 9. Records of the following five individuals with 24-Hour Rehabilitation Support Plans: JAS, JHM, MR, MRB and TS 10. List of individuals with an INPOP plan

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		<p>11. Records of the following five individuals with an INPOP plan: DM, JHM, SP, TS and VT</p> <p>12. Records for the following two individuals at high risk for falls: DG and JRB</p> <p>13. Records for the following three individuals who had three or more falls in 30 days or a fall with a major injury during the review period: IKL, JDM and JG</p> <p><u>Observed:</u></p> <ol style="list-style-type: none"> 1. Video Productions PSR Mall group 2. Creative Arts Therapy PSR Mall group 3. Pet Therapy PSR Mall group 4. Music Appreciation PSR Mall group 5. Tai Chi for Anger Management 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: Substantial.						
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The table below presents the number of scheduled and actual hours of direct services provided by OT, PT, and SLP during one week of the review period:</p> <table border="1" data-bbox="989 1339 1587 1414"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>OT</td> <td>24</td> <td>20</td> </tr> </tbody> </table>		Scheduled	Provided	OT	24	20
	Scheduled	Provided						
OT	24	20						

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		<table border="1"> <tr> <td>PT</td> <td>18</td> <td>16</td> </tr> <tr> <td>SLP</td> <td>13</td> <td>12</td> </tr> </table>	PT	18	16	SLP	13	12	<p>The facility determined that three appointments were missed due to conflicting appointments, three were missed due to individual refusal, and one appointment was missed because the individual was ill.</p> <p>Other findings: Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 31% of individuals receiving occupational, speech and/or physical therapy direct treatment during the review period (November 2009-April 2010):</p> <table border="1"> <tr> <td data-bbox="989 675 1087 751">1.</td> <td data-bbox="1087 675 1793 751"><i>The provision of direct services by rehabilitation therapy services staff</i></td> <td data-bbox="1793 675 1887 751">99%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 17 individuals receiving direct occupational, physical, and speech therapy treatment to assess compliance with F.4.a.i criteria found all records in substantial compliance</p> <p>In terms of individualized outcomes, record review found that 14 out of 17 individuals attending OT, PT, or SLP direct treatment either met or made progress towards outcomes, two individuals did not show evidence of progress and were discharged secondary to plateau in progress noted, and one individual was not seen long enough in treatment for progress to be assessed. However, it was noted that for three individuals who were discharged from treatment (AMH, DWH and JM), the Present Status section of the individuals' WRPs were not updated to reflect the change in services.</p>	1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	99%
PT	18	16										
SLP	13	12										
1.	<i>The provision of direct services by rehabilitation therapy services staff</i>	99%										

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		<p>Current recommendation: Continue to monitor this requirement.</p>			
F.4.a.ii	<p>the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 42% of plans completed during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="989 672 1887 786"> <tr> <td>2.</td> <td><i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of records of five individuals with INPOP plans to assess compliance with F.4.a.ii criteria found all records in substantial compliance.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	2.	<i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i>	100%
2.	<i>The oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.</i>	100%			
F.4.b	<p>Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p>			

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		<p>Findings: The facility reported that 112 out of 112 nurses identified as requiring training in the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence, were trained to competency during the review period. The facility's training binder was reviewed to confirm reported data.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to enhance current practice.</p>			
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 20% of individuals participating in PSR Mall groups facilitated by Rehabilitation Therapists and Vocational Rehabilitation staff during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="989 1117 1887 1230"> <tr> <td data-bbox="989 1117 1087 1230">4.</td> <td data-bbox="1087 1117 1793 1230"><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td data-bbox="1793 1117 1887 1230">98%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 82% in the previous review period.</p> <p>A review of the records of 19 individuals participating in Rehabilitation</p>	4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	98%
4.	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	98%			

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		<p>Therapist- and Vocational Rehabilitation staff-facilitated PSR Mall groups to assess compliance with F.4.c criteria found all records in substantial compliance.</p> <p>In terms of individualized outcomes, record review found that 15 out of 18 individuals attending Rehabilitation Therapy or Vocational Rehabilitation PSR Mall groups had either met or made progress towards outcomes.</p> <p>Observation of five PSR Mall groups found that in all groups, the appropriate lesson plan was in use and the groups provided activities that were in line with the individuals' assessed needs.</p> <p>The table below presents the number of hours scheduled versus number of hours provided of PSR Mall Services facilitated by Rehabilitation Therapists and Vocational Rehabilitation during the week of 2/22/10:</p> <table border="1" data-bbox="989 820 1654 937"> <thead> <tr> <th></th> <th>Scheduled</th> <th>Provided</th> </tr> </thead> <tbody> <tr> <td>RT</td> <td>749</td> <td>593</td> </tr> <tr> <td>Voc Rehab</td> <td>53</td> <td>51</td> </tr> </tbody> </table> <p>The facility reported that discrepancies between hours scheduled and hours provided was due to staff time off including furloughs, vacation, illness; staff shortages; lockdowns; and mandatory training.</p> <p>Using the DMH F.4 Monitoring Tool, PSH assessed its compliance based on an average sample of 50% of individuals with 24-hour support plans during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="989 1269 1885 1417"> <tbody> <tr> <td>4.b</td> <td><i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i></td> <td>100%</td> </tr> <tr> <td>a.</td> <td><i>The 24-hour Rehabilitation Support Plan was</i></td> <td>100%</td> </tr> </tbody> </table>		Scheduled	Provided	RT	749	593	Voc Rehab	53	51	4.b	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	100%	a.	<i>The 24-hour Rehabilitation Support Plan was</i>	100%
	Scheduled	Provided															
RT	749	593															
Voc Rehab	53	51															
4.b	<i>Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.</i>	100%															
a.	<i>The 24-hour Rehabilitation Support Plan was</i>	100%															

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		<table border="1" data-bbox="989 190 1885 342"> <tr> <td data-bbox="989 190 1087 228"></td> <td data-bbox="1087 190 1793 228"><i>implemented within 28 days of referral.</i></td> <td data-bbox="1793 190 1885 228"></td> </tr> <tr> <td data-bbox="989 228 1087 342">b.</td> <td data-bbox="1087 228 1793 342"><i>The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP</i></td> <td data-bbox="1793 228 1885 342">100%</td> </tr> </table> <p data-bbox="989 386 1885 451">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="989 495 1885 597">A review of records of five individuals with 24-hour support plans to assess compliance with F.4.c criteria found all records in substantial compliance.</p> <p data-bbox="989 641 1885 673">Other findings:</p> <p data-bbox="989 678 1885 971">A review of individuals who were at high risk for falls found evidence that Physical Therapy focused assessments were ordered and completed for two individuals for whom it was clinically indicated. Record review of three individuals who had three or more falls in 30 days or a fall resulting in major injury (IKL, JDM and JG) found no discussion of the trigger event(s) in the Present Status section of the WRP, and therefore it could not be determined whether an OT or PT focused assessment was clinically indicated.</p> <p data-bbox="989 1015 1885 1079">Compliance: Substantial.</p> <p data-bbox="989 1123 1885 1188">Current recommendation: Continue to monitor this requirement.</p>		<i>implemented within 28 days of referral.</i>		b.	<i>The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP</i>	100%
	<i>implemented within 28 days of referral.</i>							
b.	<i>The 24-hour Rehabilitation Support Plan was updated, and the rationale documented in the Present Status section of the WRP</i>	100%						
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	<p data-bbox="989 1237 1885 1269">Current findings on previous recommendation:</p> <p data-bbox="989 1312 1885 1377">Recommendation, December 2009: Continue current practice.</p>						

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	<p>independence, and shall provide individuals with training and support to use such equipment.</p>	<p>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 and 38% of individuals requiring reassessment as clinically indicated each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="989 451 1887 826"> <tr> <td data-bbox="989 451 1087 526">e.</td> <td data-bbox="1087 451 1793 526"><i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i></td> <td data-bbox="1793 451 1887 526">100%</td> </tr> <tr> <td data-bbox="989 526 1087 600">f.</td> <td data-bbox="1087 526 1793 600"><i>The individual was provided with the equipment as per the doctor's order</i></td> <td data-bbox="1793 526 1887 600">100%</td> </tr> <tr> <td data-bbox="989 600 1087 675">g.</td> <td data-bbox="1087 600 1793 675"><i>The individual's level of functioning related to independence versus supports needed was assessed.</i></td> <td data-bbox="1793 600 1887 675">100%</td> </tr> <tr> <td data-bbox="989 675 1087 750">h.</td> <td data-bbox="1087 675 1793 750"><i>Training for the individual on the use of adaptive equipment was provided.</i></td> <td data-bbox="1793 675 1887 750">100%</td> </tr> <tr> <td data-bbox="989 750 1087 826">i.</td> <td data-bbox="1087 750 1793 826"><i>Reassessment of adaptive equipment, if clinically indicated</i></td> <td data-bbox="1793 750 1887 826">100%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%	f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%	g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%	h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%	i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%
e.	<i>The individual was assessed for the appropriateness of adaptive equipment by an RT professional</i>	100%															
f.	<i>The individual was provided with the equipment as per the doctor's order</i>	100%															
g.	<i>The individual's level of functioning related to independence versus supports needed was assessed.</i>	100%															
h.	<i>Training for the individual on the use of adaptive equipment was provided.</i>	100%															
i.	<i>Reassessment of adaptive equipment, if clinically indicated</i>	100%															

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5. Nutrition Services		
	<p>Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Brian Starck-Riley, Assistant Director of Nutrition Services 2. Diana Tran, Assistant Director of Nutrition Services 3. Jeanie Kim, Assistant Director of Nutrition Services 4. Tai Kim, Director of Nutrition Services 5. Vivian Collins, Acting Assistant Director of Nutrition Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Lists of individuals with Nutrition Care Assessments due from November 2009-April 2010 for each assessment type 2. Records of the following 52 individuals with types a-j.ii assessments from November 2009-April 2010: ADH, AP, AR, BLM, CA, CC, CES, CG, CGT, CK, CRH, CSA, DB, DDR, DEB, DGG, EDH, EMM, GF, GFW, GNF, GPR, HC, JCS, JDM, JLB, JM, JPD, JRH, JSC, JV, LAG, LTH, MEJ, MG, MH, MR, NP, PS, RA, RJ, RJB, RM, SC, SS, SVE, TE, TG, TO, TS, VD and WDW 3. Meal Accuracy Report audit data from November 2009-April 2010 4. Nutrition Care Monitoring Tool audit data from November 2009-April 2010 regarding Nutrition Education Training, response to MNT, and WRP integration of Nutrition Services recommendations (weighted mean across assessment sub-types) 5. List of individuals at risk for choking 6. Record for the following individual at risk for choking: JH 7. Records for the following two individuals with an incident of choking during the review period: GRA and LWS 8. List of individuals at risk for aspiration 9. Records for the following two individuals at risk for aspiration: JWJ and RKB 10. List of individuals with a new diabetes diagnosis during the review period

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		<p>11. Records for the following individuals with a new diabetes diagnosis of diabetes during the review period: AB and OVM</p> <p>12. List of individuals at risk for metabolic syndrome</p> <p>13. Records for the following five individuals at high risk for metabolic syndrome: AC, EG, JB, JJM and NCA</p> <p><u>Observed:</u> Win Over Weight PSR Mall group</p>						
F.5.a	<p>Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance based on an average sample of 19% of Nutrition Assessments (all types) due each month from November 2009-April 2010 (total of 502 out of 2602):</p> <table border="1" data-bbox="989 932 1887 1083"> <tr> <td data-bbox="989 932 1087 971">7.</td> <td data-bbox="1087 932 1793 971"><i>Nutrition education is documented.</i></td> <td data-bbox="1793 932 1887 971">97%</td> </tr> <tr> <td data-bbox="989 971 1087 1083">8</td> <td data-bbox="1087 971 1793 1083"><i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i></td> <td data-bbox="1793 971 1887 1083">99%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period for both items.</p> <p>A review of the records of 52 individuals to assess compliance with documentation of provision of Nutrition Education Training and of response to Medical Nutrition Training found all records in substantial compliance.</p>	7.	<i>Nutrition education is documented.</i>	97%	8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	99%
7.	<i>Nutrition education is documented.</i>	97%						
8	<i>Response to MNT is specific to the intervention provided, adherence potential indicated, and barriers identified.</i>	99%						

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		<p>PSH assessed its compliance with tray accuracy based on an average sample of 22% of average daily census from September 2009-February 2010 (total of 2006 out of 9024) and found that 99% of trays audited were in 100% compliance.</p> <p>Other findings: A review of records for three individuals at high risk for metabolic syndrome and with a new diagnosis of diabetes (JB, JJM and NCA) found that all records had evidence of a nutrition assessment that addressed either risk factors or appropriate contributing factors and had evidence of an objective and intervention in place to reduce risk implemented by the dietitian and in line with findings of nutrition assessment and recommendations. Record reviews for two individuals with a new diabetes diagnosis (AB and OVM) and one individual at high risk for metabolic syndrome (EG) found that nutrition consultation was not ordered when it appeared to be clinically indicated.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
F.5.b	<p>Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current efforts to achieve compliance.</p> <p>Findings: Using the DMH Nutrition Care Monitoring Tool, PSH assessed its compliance with WRP integration based on an average sample of 19% of Nutrition Assessments (all types) due each month from November 2009-April 2010 (502 out of 2602):</p>

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19.	<i>The WRP has at least ONE Focus that pertains to nutrition recommendations as clinically indicated</i>	96%
20.	<i>The WRP has at least one objective and intervention linked to the Focus that pertains to the nutrition recommendation as clinically indicated</i>	63%

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

	Previous period	Current period
Mean compliance rate		
19.	94%	95%
20.	56%	63%

The facility reported that less than substantial compliance with item 20 is due to RD vacancies and high caseloads of an average of 150 individuals for each dietitian.

A review of the records of 22 individuals with completed Nutrition Care assessments to assess compliance with integration of adequate focus, objective and intervention into the WRP found 19 records in substantial compliance (AR, BLM, CES, CG, DDR, DEB, ER, ET, GF, GNF, JDM, JLB, JM, JSC, MEJ, MG, SC, TG and TS) and three records not in compliance (ADH, CRH and DGG).

Compliance:
Partial.

Current recommendation:
Continue current efforts to improve compliance.

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<p>F.5.c</p>	<p>Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: No incidences of aspiration pneumonia were reported during the review period.</p> <p>Current dysphagia procedures and screening tools should continue to be updated to reflect standards of practice and to ensure consistency with procedures at other state hospitals.</p> <p>Other findings: A review of the records of two individuals with an incident of choking found that both individuals had an assessment by a speech therapist with subsequent recommendations incorporated into the treatment plan. A review of the records of three individuals at high risk for choking and/or aspiration found that two of the three records contained documentation an open focus, objective and intervention to remediate risk and/or future occurrence (JH and JWL), and one had evidence of the risk in the present status but no open focus to address the risk (RKB).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
<p>F.5.d</p>	<p>Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p>

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	<p>commensurate with their responsibilities.</p>	<p>Findings: No new Dietitians were hired during the review period, and therefore no training on basic issues related to aspiration and dysphagia was necessary.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>F.5.e</p>	<p>Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The facility reported that no individuals currently receive enteral nutrition. The DMH Statewide Dietetics Department Policy for Tube Feeding appears to meet accepted standards of practice.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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6. Pharmacy Services																																											
	<p>Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Laura Yao, Business Manager II 2. Washington Ubillus, Jr., Pharmacist I <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH self-assessment monitoring data 2. Executive Summary - Pharmacists' recommendations regarding new psychotropic medication orders and physicians' response to these recommendations during this reporting period 																																									
F.6.a	<p>Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: PSH presented the following data:</p> <table border="1" data-bbox="991 971 1873 1393"> <thead> <tr> <th></th> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Drug-drug interactions</td> <td>128</td> <td>64</td> </tr> <tr> <td>2.</td> <td>Side effects</td> <td>82</td> <td>100</td> </tr> <tr> <td>3.</td> <td>Need for laboratory testing</td> <td>139</td> <td>222</td> </tr> <tr> <td>4.</td> <td>Dose adjustment</td> <td>73</td> <td>72</td> </tr> <tr> <td>5.</td> <td>Indications</td> <td>0</td> <td>9</td> </tr> <tr> <td>6.</td> <td>Contraindications</td> <td>18</td> <td>9</td> </tr> <tr> <td>7.</td> <td>Need for continued treatment</td> <td>0</td> <td>0</td> </tr> <tr> <td>8.</td> <td>Other</td> <td>61</td> <td>21</td> </tr> <tr> <td colspan="2">Total number of recommendations*</td> <td>501</td> <td>497</td> </tr> </tbody> </table>				Previous period	Current period	1.	Drug-drug interactions	128	64	2.	Side effects	82	100	3.	Need for laboratory testing	139	222	4.	Dose adjustment	73	72	5.	Indications	0	9	6.	Contraindications	18	9	7.	Need for continued treatment	0	0	8.	Other	61	21	Total number of recommendations*		501	497
		Previous period	Current period																																								
1.	Drug-drug interactions	128	64																																								
2.	Side effects	82	100																																								
3.	Need for laboratory testing	139	222																																								
4.	Dose adjustment	73	72																																								
5.	Indications	0	9																																								
6.	Contraindications	18	9																																								
7.	Need for continued treatment	0	0																																								
8.	Other	61	21																																								
Total number of recommendations*		501	497																																								

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>												
F.6.b	Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: The facility presented the following data:</p> <table border="1" data-bbox="993 711 1797 976"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td>Recommendations followed</td> <td>465</td> <td>450</td> </tr> <tr> <td>Recommendations not followed, but rationale documented</td> <td>27</td> <td>39</td> </tr> <tr> <td>Recommendations not followed and rationale/response not documented</td> <td>9</td> <td>8</td> </tr> </tbody> </table> <p>Other findings: This monitor reviewed the facility's documents regarding eight pharmacy recommendations that were not followed by the physicians or no response was documented. The review did not find evidence of harm to the individuals in any case. However, all such recommendations require response from the medical staff, including justification of the decision not to follow the recommendation.</p> <p>Compliance: Substantial.</p>		Previous period	Current period	Recommendations followed	465	450	Recommendations not followed, but rationale documented	27	39	Recommendations not followed and rationale/response not documented	9	8
	Previous period	Current period												
Recommendations followed	465	450												
Recommendations not followed, but rationale documented	27	39												
Recommendations not followed and rationale/response not documented	9	8												

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		Current recommendation: Continue to monitor this requirement.
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Section F: Specific Therapeutic and Rehabilitation Services

7. General Medical Services		
		<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Chinh Pham, MD, Physician and Surgeon 2. Christopher Elder, Nursing Coordinator 3. Darrell Brown, Administrator Medical Services 4. Dien Mach, MD, Chief Physician and Surgeon 5. Doan Bong, MD, Physician and Surgeon 6. Dominique Tran, MD, Physician and Surgeon 7. Dung Tran, MD, Physician and Surgeon 8. George Christison, MD, Acting Medical Director 9. Hai Le, MD, Physician and Surgeon 10. Joshua Horsley, MD, Psychiatrist 11. Kenny Win, MD, Physician and Surgeon 12. Khanh Ngo, MD, Physician and Surgeon 13. Khue Nguyen, MD, Physician and Surgeon 14. Lidia Lau, RN, Assistant Coordinator, Nursing Services 15. Luminita Andronescu, MD, Physician and Surgeon 16. Luzmin Inderias, MD, Physician and Surgeon 17. Mohamed Hafez, MD, Physician and Surgeon 18. My Tran, MD, Physician and Surgeon 19. Nibonth Viravathana, MD, Physician and Surgeon 20. Rebecca Kornbluh, MD, Acting Chief of Psychiatry 21. Sang Chung, MD, Physician and Surgeon 22. Susan Protacio, MD, Physician and Surgeon <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. The charts of the following 10 individuals who were transferred to an outside medical facility during this reporting period: DJ-1, DJ-2, GO, JG-1, JG-2, JL, RC, RF, RG, and SA 2. Quarterly progress notes for the following 17 individuals: BLC, BLM, CG, CLH, DJ, EG, ER, HC, LF, MF, NT, PS, RS, SA, SH, TPS, and YP

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		<ol style="list-style-type: none"> 3. Reference for Assessment and Notification (RAN) for Altered Mental Status, Abdominal Pain, Gastrointestinal Bleed, Respiratory, Cardiovascular, and Infection 4. List of all individuals admitted to external hospitals during the review period 5. List of individuals referred for a "Seizure Battery" to assess cognition 6. PSH Integration of Medical Conditions into the WRP Auditing summary data (November 2009-April 2010) 7. PSH Medical Transfer Auditing summary data (November 2009-April 2010) 8. PSH Diabetes Mellitus Auditing summary data (November 2009-April 2010) 9. PSH Hypertension Auditing summary data (November 2009-April 2010) 10. PSH Dyslipidemia Auditing summary data (November 2009-April 2010) 11. PSH Asthma/COPD Auditing summary data (November 2009-April 2010) 12. PSH Clozapine auditing summary data (November 2009-April 2010) 13. PSH Seizure auditing summary data (February to April 2010) 14. PSH Medicine Peer Review data (November 2009-April 2010) 15. PSH Process and Clinical Outcome summary data (previous and current reporting period) for the following indicators: <ul style="list-style-type: none"> • Diabetes Mellitus • Dyslipidemia • Obesity • Hypertension • Bowel Dysfunction • Falls • Aspiration Pneumonia • Seizure Disorder • Specialty Consultations
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		<ul style="list-style-type: none"> • Unexpected Mortalities
<p>F.7.a</p>	<p>Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Implement corrective actions to address the monitor's findings of deficiencies listed [in this cell in the previous report].</p> <p>Findings: PSH has implemented the following corrective actions for each area of deficiency:</p> <ol style="list-style-type: none"> 1. Clozaril use in presence of bowel dysfunction: <ol style="list-style-type: none"> a. The Physicians and Surgeons were to be notified by nursing staff when an individual on clozapine has not had a bowel movement for three consecutive days and to assess the individual and provide instructions for further follow-up. b. Individuals on clozapine will be placed on a high-fiber diet and enrolled in aerobic exercise programs. c. An auditing mechanism to monitor these practices was developed and implemented. d. The facility collected process outcome data about the number of individuals who are receiving clozapine and the number of individuals hospitalized for bowel dysfunction (please see F.7.d). 2. Behavioral interventions for individuals suffering from water intoxication: The facility implemented PSH Water Intoxication Psychosocial Treatment Programs (SIFI2) to address the behavioral intervention component of management of individuals who suffered water intoxication. 3. Tracking of seizure activity: <ol style="list-style-type: none"> a. Nursing staff were prompted to document the description of seizure activity utilizing the seizure record (MH5601). b. The Physicians and Surgeons were reminded to evaluate

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		<p>individuals who were reported to have had a seizure episode, to review seizure records for each occurrence and to refer the individuals for neurology consultations when clinically indicated.</p> <p>c. The Neurology Consultant was requested to provide a morphological diagnosis of the seizure disorder and to address the appropriateness of the medication selection for the diagnosed seizure type and the negative impact of the selected medication (especially the old-generation AEDs) on cognition as evidenced by neuropsychological evaluation.</p> <p>d. An auditing mechanism to monitor these practices was developed and implemented (see F.7.d).</p> <p>Recommendation 2, December 2009: Provide a summary outline of any changes in the current medical and joint medical nursing ADs, policies and procedures.</p> <p>Findings: PSH reported that Policies and Procedures 1.10: History and Physical Examinations and 1.14: Primary Care Physician Responsibilities were revised to address individuals' refusals, with implementation dates of May 1 and May 15, 2010 respectively.</p> <p>Other findings: This monitor reviewed the charts of 10 individuals who were transferred to an outside medical facility on 11 occasions during this reporting period. The following table outlines the episodes of transfer review by date/time of physician evaluation at the time of transfer and the reason for the transfer (individuals have been anonymized):</p> <table border="1" data-bbox="991 1263 1873 1414"> <thead> <tr> <th>Individual</th> <th>Date of transfer</th> <th>Reason for transfer</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>11/30/09</td> <td>New onset seizure</td> </tr> <tr> <td>2</td> <td>12/4/09</td> <td>Elevated Lipase (R/O Pancreatitis)</td> </tr> </tbody> </table>	Individual	Date of transfer	Reason for transfer	1	11/30/09	New onset seizure	2	12/4/09	Elevated Lipase (R/O Pancreatitis)
Individual	Date of transfer	Reason for transfer									
1	11/30/09	New onset seizure									
2	12/4/09	Elevated Lipase (R/O Pancreatitis)									

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		3	12/8/09	Foreign Body Ingestion
		4	12/10/09	Seizure and fall
		5	3/10/10	S/P Head Trauma
		6	3/17/10	R/O Ileus
		7	3/25/10	Seizure
		8	4/7/10	Lethargy (medication error)
		9	4/7/10	Appendicitis
		10	4/9/10	Hyponatremia S/P Head Trauma
		6	4/12/10	Fever and lethargy
		<p>The review found that medical care was, in general, timely and appropriate and that significant progress was made to address the process deficiencies outlined in previous reports. However, this monitor found the following deficiencies:</p> <ol style="list-style-type: none"> 1. There was no evidence of nursing assessment of an individual who complained of abdominal pain, and a physician ordered a PRN medication without examining the individual. This individual was transferred to the hospital the next day with a diagnosis of appendicitis. 2. There appeared to be a delay in the management of the risk of recurrent pancreatitis in an individual who continued to receive high-risk treatment with divalproex after experiencing an episode of pancreatitis. The individual suffered a recurrence of pancreatitis while still receiving this high-risk treatment. 3. There was no documentation of tracking of seizure activity on March 4, 2010 in an individual who experienced several recurrences of seizure activity within the same month. 4. There was no documentation of seizure tracking in an individual who experienced new-onset seizure activity for six minutes on November 30, 2009. 		

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		<p>Compliance: Substantial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure consistency of nursing assessments of changes in the status of individuals, including abdominal pain and tracking of seizure activity. 2. Provide a summary outline of any changes in the current medical and joint medical nursing ADs, policies and procedures. 									
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.									
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Medical Surgical Progress Notes Auditing Form, PSH assessed its compliance based on an average sample of 18% of all individuals with at least one diagnosis on Axis III during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1117 1892 1416"> <tr> <td data-bbox="991 1117 1087 1192">1.</td> <td data-bbox="1087 1117 1793 1192"><i>There is a quarterly note that documents reassessment of the individual's medical status.</i></td> <td data-bbox="1793 1117 1892 1192">98%</td> </tr> <tr> <td data-bbox="991 1192 1087 1305">2.</td> <td data-bbox="1087 1192 1793 1305"><i>There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i></td> <td data-bbox="1793 1192 1892 1305">100%</td> </tr> <tr> <td data-bbox="991 1305 1087 1416">3.</td> <td data-bbox="1087 1305 1793 1416"><i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call</i></td> <td data-bbox="1793 1305 1892 1416">98%</td> </tr> </table>	1.	<i>There is a quarterly note that documents reassessment of the individual's medical status.</i>	98%	2.	<i>There is appropriate and timely response and documentation from the treating physician meeting the standards of care for the condition being treated.</i>	100%	3.	<i>If applicable, the on call (after hours) physician documents in the PPN necessary communication between the regular medical physician and the on-call</i>	98%
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		<table border="1" data-bbox="991 188 1887 266"> <tr> <td data-bbox="991 188 1087 266"></td> <td data-bbox="1087 188 1793 266"><i>(after hours) physician regarding changes in the individual's physical condition.</i></td> <td data-bbox="1793 188 1887 266"></td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>Other findings: This monitor reviewed quarterly progress notes for the following 17 individuals: BLC, BLM, CG, CLH, DJ, EG, ER, HC, LF, MF, NT, PS, RS, SA, SH, TPS, and YP. The notes were selected to represent all practitioners. The review found that the new format of quarterly reassessments was adequately implemented.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>(after hours) physician regarding changes in the individual's physical condition.</i>	
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F.7.b.ii	<p>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Provide information based on the Medical Emergency Response Evaluation Form that the facility has implemented.</p> <p>Findings: PSH has provided data on its reviews of the Medical Emergency Response System. Using the DMH Medical Emergency Response MH-C 9128 Form, PSH assessed its compliance based on a sample of 100% of actual medical emergencies during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1341 1887 1414"> <tr> <td data-bbox="991 1341 1087 1414">1.</td> <td data-bbox="1087 1341 1793 1414"><i>Did the first responder appropriately assess and call for help?</i></td> <td data-bbox="1793 1341 1887 1414">100%</td> </tr> </table>	1.	<i>Did the first responder appropriately assess and call for help?</i>	100%
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		2.	<i>Did the first responder provide appropriate CPR procedures?</i>	100%
		3.	<i>Did the first responder provide appropriate rescue breathing procedures?</i>	100%
		4.	<i>Did the first responder provide Heimlich procedures?</i>	N/A
		5.	<i>Did the first responder provide appropriate BFA procedures?</i>	N/A
		6.	<i>Did the individual suffer any complications (e.g. fractured ribs, aspiration)?</i>	0
		7.	<i>Did the RN respond in a timeframe consistent with the emergency?</i>	100%
		8.	<i>Did the MD respond within 15 minutes?</i>	100%
		9.	<i>Did a sufficient number of staff respond in a timeframe to assure an adequate number of trained staff were available to run the code efficiently?</i>	100%
		10.	<i>Was the unit milieu appropriately managed?</i>	100%
		11.	<i>Was all required equipment available?</i>	94%
		12.	<i>Was all required equipment in working order?</i>	88%
		13.	<i>Were all medical supplies available?</i>	100%
		14.	<i>Were all medications available?</i>	94%
		15.	<i>Was the overall response organized in a manner that led to the best outcome for the individual?</i>	100%
		16.	<i>Did all the staff perform according to assigned roles?</i>	98%
		17.	<i>Was staff competent in operating equipment?</i>	100%
		18.	<i>Was the announcement "Code Blue" timely and clear?</i>	88%
		19.	<i>Was all required documentation completed?</i>	100%
		20.	<i>Was EMS able to access the site in a timely manner?</i>	100%
		21.	<i>Was the equipment restocking completed within 8 hours?</i>	88%
		Using the above-referenced form, PSH also assessed its compliance based on a sample of 100% of medical emergency drills conducted during		

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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;"><i>hours?</i></td> <td style="width: 50%;"></td> </tr> </table> <p>Comparative data is not available for either drills or actual medical emergencies as auditing commenced during the current review period.</p> <p>Other findings: During this review period, PSH has implemented an adequate process to review the performance of medical emergency drills, identify areas of concern, and develop and implement corrective actions. The following is a summary of areas identified in some of the drills and corresponding corrections:</p> <ol style="list-style-type: none"> 1. Only one drug box was brought to the scene instead of the required two. Nursing staff was reminded about the requirement. 2. Staff performed the CPR compressions at the previous ratio of 15:2 (the new ratio of 30:2 has been taught at the facility for the last two years). Copies of the CPR algorithm for adults were highlighted for the current ratio of 30:2 and sent to all units with instructions to post them in the nursing station. 3. Staff was deficient in performing CPR. All staff participating in the drills needed to re-take CPR classes. Program Management was notified to submit copies of sign-in sheets as proof of compliance. 4. Not enough staff participated in the drills. Drills were repeated on all affected units with the required number of staff. <p>In addition, the facility reported that in March 2010, drill scenarios were reviewed and improved to ensure that they reflect real-life scenarios, including scripted individual responses (vital signs, oxygen saturation, etc.) to various treatment interventions. The Health Services Specialists who provided drill training were in-serviced on these updated scenarios in April 2010.</p> <p>During this review period, two code blue medical emergencies occurred on</p>	<i>hours?</i>	
<i>hours?</i>				

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		<p>hospital grounds. The facility assessed that these emergencies were managed well but it was decided that a drill will be conducted on grounds once per quarter to ensure that staff has practice handling emergencies in areas in which equipment is not readily available.</p> <p>Recommendation 2, December 2009: Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</p> <p>Findings: Using the DMH Medical Transfer Auditing Form, PSH assessed its compliance based on a 100% sample of medical transfers during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 743 1890 1416"> <tr> <td data-bbox="991 743 1087 857">1.</td> <td data-bbox="1087 743 1793 857"><i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i></td> <td data-bbox="1793 743 1890 857">97%</td> </tr> <tr> <td data-bbox="991 857 1087 1003">2.</td> <td data-bbox="1087 857 1793 1003"><i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i></td> <td data-bbox="1793 857 1890 1003">96%</td> </tr> <tr> <td data-bbox="991 1003 1087 1084">3.</td> <td data-bbox="1087 1003 1793 1084"><i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i></td> <td data-bbox="1793 1003 1890 1084">94%</td> </tr> <tr> <td data-bbox="991 1084 1087 1230">4.</td> <td data-bbox="1087 1084 1793 1230"><i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i></td> <td data-bbox="1793 1084 1890 1230">96%</td> </tr> <tr> <td data-bbox="991 1230 1087 1383">5.</td> <td data-bbox="1087 1230 1793 1383"><i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i></td> <td data-bbox="1793 1230 1890 1383">94%</td> </tr> <tr> <td data-bbox="991 1383 1087 1416">6.</td> <td data-bbox="1087 1383 1793 1416"><i>Timely written progress notes by the regular medial</i></td> <td data-bbox="1793 1383 1890 1416">98%</td> </tr> </table>	1.	<i>There is appropriate documentation by the nurse that identifies the symptoms of concern and notification of the physician.</i>	97%	2.	<i>There is appropriate and timely response and documentation from the transferring physician meeting the standards of care for the condition being transferred.</i>	96%	3.	<i>Sufficient information is provided to the accepting facility in order to ensure continuity of care.</i>	94%	4.	<i>Sufficient information is provided by the external facility (acute medical care facility/emergency department) at the time of discharge in order to ensure the continuity of care.</i>	96%	5.	<i>Upon return from acute medical treatment, the accepting physician provides an appropriate note describe the course of treatment provided at the acute medical facility.</i>	94%	6.	<i>Timely written progress notes by the regular medial</i>	98%
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		<p><i>physician shall address the treatment provided at the acute medical facility and follow-up treatment provided at the DMH hospital.</i></p>																
		<p>7. <i>The WRP was updated to reflect the individual's current status following hospitalization or emergency room treatment.</i></p>	<p>90%</p>															
		<p>Comparative data indicated maintenance of a compliance rate of at least 90% from the previous review period for items 1, 2, 5 and 6, and improvement in the remaining items as follows:</p>																
		<table border="1"> <thead> <tr> <th data-bbox="978 597 1520 678"></th> <th data-bbox="1520 597 1713 678">Previous period</th> <th data-bbox="1713 597 1904 678">Current period</th> </tr> </thead> <tbody> <tr> <td data-bbox="978 678 1904 716" style="background-color: #e0e0e0;">Mean compliance rate</td> <td data-bbox="1520 678 1713 716"></td> <td data-bbox="1713 678 1904 716"></td> </tr> <tr> <td data-bbox="978 716 1520 753">3.</td> <td data-bbox="1520 716 1713 753">80%</td> <td data-bbox="1713 716 1904 753">94%</td> </tr> <tr> <td data-bbox="978 753 1520 790">4.</td> <td data-bbox="1520 753 1713 790">87%</td> <td data-bbox="1713 753 1904 790">96%</td> </tr> <tr> <td data-bbox="978 790 1520 831">7.</td> <td data-bbox="1520 790 1713 831">78%</td> <td data-bbox="1713 790 1904 831">90%</td> </tr> </tbody> </table>			Previous period	Current period	Mean compliance rate			3.	80%	94%	4.	87%	96%	7.	78%	90%
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3.	80%	94%																
4.	87%	96%																
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		<p>PSH also used the DMH Integration of Medical Conditions into the WRP Auditing Form to assess compliance. The average sample was 21% of the WRPs due each month for individuals with at least one diagnosis on Axis III during the review period (November 2009-April 2010). The following is a summary of the data:</p>																
		<p>1. <i>All medical conditions listed in Axis III are included on the Medical Conditions Form.</i></p>	<p>94%</p>															
		<p>2. <i>The WRP includes each medical condition listed on the Medical Conditions Form.</i></p>	<p>91%</p>															
		<p>3. <i>There is an appropriate focus statement for each medical condition or diagnosis</i></p>	<p>91%</p>															
		<p>4. <i>There is an appropriate objective for each medical condition or diagnosis</i></p>	<p>91%</p>															

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		<p>5. <i>There are appropriate intervention(s) for each objective</i></p>	<p>90%</p>																					
<p>Comparative data indicated improvement in compliance since the previous review period:</p>																								
<table border="1"> <thead> <tr> <th></th> <th>Previous period</th> <th>Current period</th> </tr> </thead> <tbody> <tr> <td colspan="3">Mean compliance rate</td> </tr> <tr> <td>1.</td> <td>76%</td> <td>94%</td> </tr> <tr> <td>2.</td> <td>71%</td> <td>91%</td> </tr> <tr> <td>3.</td> <td>47%</td> <td>91%</td> </tr> <tr> <td>4.</td> <td>64%</td> <td>91%</td> </tr> <tr> <td>5.</td> <td>49%</td> <td>90%</td> </tr> </tbody> </table>					Previous period	Current period	Mean compliance rate			1.	76%	94%	2.	71%	91%	3.	47%	91%	4.	64%	91%	5.	49%	90%
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<p>Using the same tool, the facility reviewed a 100% sample of individuals who have refused medical treatment or laboratory tests. The following is a summary of the data:</p>																								
<table border="1"> <tr> <td data-bbox="976 901 1087 1023">6.</td> <td data-bbox="1087 901 1793 1023"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i></td> <td data-bbox="1793 901 1921 1023">98%</td> </tr> </table>				6.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals of medical procedures</i>	98%																		
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<p>Comparative data indicated improvement in compliance from 30% in the previous review period.</p>																								
<p>Compliance: Substantial.</p>																								
<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Continue to monitor this requirement. 2. In order to maintain substantial compliance, provide a summary outline of the issues identified during the performance of medical 																								

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		emergency drills and corresponding corrective actions.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The facility has continued its practice. The physicians' duty statements are aligned with administrative directives and policies and procedures regarding Provision of Medical Care to Individuals, RN and Physician Communication About Physical Status Change, Transfer and Return from Another Facility for Evaluation and/or Medical or Surgical Treatment, History and Physical Examinations, Procedures for Off-Site Referrals, Emergency Medical Response and Primary Care Physician Responsibilities.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: PSH has continued its practice. Review of the schedule of on-call coverage found that both a Primary Care Physician and a Psychiatrist provided after-hours coverage.</p>

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		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: The facility presented data based on a 100% sample of individuals returning from outside medical treatment during the review period (November 2009-April 2010) tracking whether required documents from outside consultants/hospitals were received within seven days of the individual's return to the facility. The mean compliance rate was 94% compared to 88% during the previous review period.</p> <p>Other findings: This monitor's reviews (see F.7.a) found that discharge summaries from outside hospitals were available in all charts that were selected for this review.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement</p>
F.7.c	Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional	<p>Current findings on previous recommendation:</p>

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	<p>standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</p>	<p>Recommendation, December 2009: Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).</p> <p>Findings: PSH used the DMH standardized tools to assess compliance regarding the management of diabetes mellitus, hypertension, dyslipidemia and asthma/COPD. The average samples were 18% (diabetes mellitus), 18% (hypertension), 19% (dyslipidemia) and 16% (COPD/asthma) of individuals diagnosed with these disorders during the review months (November 2009-April 2010). The following tables summarize the facility's data:</p> <p><u>Diabetes Mellitus</u></p> <table border="1" data-bbox="991 743 1890 1425"> <tr> <td>1.</td> <td><i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i></td> <td>97%</td> </tr> <tr> <td>2.</td> <td><i>HgbA1C was ordered quarterly.</i></td> <td>99%</td> </tr> <tr> <td>3.</td> <td><i>The HgbA1C is equal to or less than 7%.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>Blood sugar is monitored regularly.</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>Urinary micro albumin is monitored annually.</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i></td> <td>100%</td> </tr> <tr> <td>8.</td> <td><i>LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL.</i></td> <td>100%</td> </tr> <tr> <td>9.</td> <td><i>Blood pressure is monitored weekly.</i></td> <td>95%</td> </tr> <tr> <td>10.</td> <td><i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i></td> <td>98%</td> </tr> <tr> <td>11.</td> <td><i>An eye exam by an ophthalmologist/optometrist was</i></td> <td>97%</td> </tr> </table>	1.	<i>The individual has been evaluated and supporting documentation is completed at least quarterly.</i>	97%	2.	<i>HgbA1C was ordered quarterly.</i>	99%	3.	<i>The HgbA1C is equal to or less than 7%.</i>	100%	4.	<i>Blood sugar is monitored regularly.</i>	99%	5.	<i>Urinary micro albumin is monitored annually.</i>	99%	6.	<i>If the urine micro albumin level is greater than 30, ACE or ARP is prescribed, if not otherwise contraindicated.</i>	99%	7.	<i>The lipid profile is monitored on admission or time of diagnosis and at least annually.</i>	100%	8.	<i>LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL.</i>	100%	9.	<i>Blood pressure is monitored weekly.</i>	95%	10.	<i>If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure.</i>	98%	11.	<i>An eye exam by an ophthalmologist/optometrist was</i>	97%
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			<i>completed at least annually.</i>	
		12.	<i>Podiatry care was provided by a podiatrist at least annually.</i>	96%
		13.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	99%
		14.	<i>Diabetes is addressed in Focus 6 of the WRP.</i>	97%
		15.	<i>Focus 6 for Diabetes has appropriate objectives and interventions for this condition.</i>	97%
<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Hypertension</u></p>				
		1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	95%
		2.	<i>Blood pressure is monitored weekly.</i>	100%
		3.	<i>Blood pressure is less than 140/90 or there is an appropriate plan of care in place to reduce blood pressure.</i>	100%
		4.	<i>If the individual is 40 or older, aspirin has been ordered unless contraindicated.</i>	97%
		5.	<i>Hypertension is addressed in Focus 6 of the WRP.</i>	100%
		6.	<i>Focus 6 for Hypertension has appropriate objectives and interventions.</i>	99%
		7.	<i>A dietary consult was considered and the recommendation was followed, as applicable.</i>	99%
		8.	<i>The BMI is less than or equal to 25 and the waist circumference is less than 40 for males and less than 35 for females or a weight management program has been initiated.</i>	99%
		9.	<i>An exercise program has been initiated.</i>	97%

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		<table border="1"> <tr> <td data-bbox="989 190 1087 267">10.</td> <td data-bbox="1087 190 1795 267"><i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i></td> <td data-bbox="1795 190 1894 267">100%</td> </tr> </table>	10.	<i>If the individual is currently a smoker, smoking cessation has been discussed and included in the WRP.</i>	100%	<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>Dyslipidemia</u></p> <table border="1"> <tr> <td data-bbox="989 488 1087 566">1.</td> <td data-bbox="1087 488 1795 566"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1795 488 1894 566">98%</td> </tr> <tr> <td data-bbox="989 566 1087 605">2.</td> <td data-bbox="1087 566 1795 605"><i>A lipid panel was ordered at least quarterly.</i></td> <td data-bbox="1795 566 1894 605">99%</td> </tr> <tr> <td data-bbox="989 605 1087 680">3.</td> <td data-bbox="1087 605 1795 680"><i>The HDL level is >40(M) or >50(F) or a plan of care is in place.</i></td> <td data-bbox="1795 605 1894 680">100%</td> </tr> <tr> <td data-bbox="989 680 1087 719">4.</td> <td data-bbox="1087 680 1795 719"><i>The LDL level is ≤ 130 or a plan of care is in place.</i></td> <td data-bbox="1795 680 1894 719">100%</td> </tr> <tr> <td data-bbox="989 719 1087 794">5.</td> <td data-bbox="1087 719 1795 794"><i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i></td> <td data-bbox="1795 719 1894 794">100%</td> </tr> <tr> <td data-bbox="989 794 1087 833">6.</td> <td data-bbox="1087 794 1795 833"><i>Dyslipidemia is addressed in focus 6 of the WRP.</i></td> <td data-bbox="1795 794 1894 833">98%</td> </tr> <tr> <td data-bbox="989 833 1087 907">7.</td> <td data-bbox="1087 833 1795 907"><i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i></td> <td data-bbox="1795 833 1894 907">98%</td> </tr> <tr> <td data-bbox="989 907 1087 982">8.</td> <td data-bbox="1087 907 1795 982"><i>A dietary consultation was considered and the recommendation followed, as applicable.</i></td> <td data-bbox="1795 907 1894 982">99%</td> </tr> <tr> <td data-bbox="989 982 1087 1131">9.</td> <td data-bbox="1087 982 1795 1131"><i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i></td> <td data-bbox="1795 982 1894 1131">98%</td> </tr> <tr> <td data-bbox="989 1131 1087 1170">10.</td> <td data-bbox="1087 1131 1795 1170"><i>An exercise program has been initiated.</i></td> <td data-bbox="1795 1131 1894 1170">98%</td> </tr> <tr> <td data-bbox="989 1170 1087 1281">11.</td> <td data-bbox="1087 1170 1795 1281"><i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i></td> <td data-bbox="1795 1170 1894 1281">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	98%	2.	<i>A lipid panel was ordered at least quarterly.</i>	99%	3.	<i>The HDL level is >40(M) or >50(F) or a plan of care is in place.</i>	100%	4.	<i>The LDL level is ≤ 130 or a plan of care is in place.</i>	100%	5.	<i>The Triglyceride level is ≤ 200 or a plan of care is in place.</i>	100%	6.	<i>Dyslipidemia is addressed in focus 6 of the WRP.</i>	98%	7.	<i>Focus 6 for Dyslipidemia has appropriate objectives and interventions for this condition.</i>	98%	8.	<i>A dietary consultation was considered and the recommendation followed, as applicable.</i>	99%	9.	<i>BMI is less than or equal to 25 and the waist circumference is less than 40 (males) and less than 35 (females) or a weight management program has been initiated.</i>	98%	10.	<i>An exercise program has been initiated.</i>	98%	11.	<i>If non-pharmacological interventions have been ineffective to control Dyslipidemia, medications have been considered or initiated.</i>	99%
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		<p><u>Asthma/COPD</u></p> <table border="1"> <tr> <td data-bbox="991 266 1087 341">1.</td> <td data-bbox="1087 266 1793 341"><i>The individual has been evaluated and supporting documentation completed at least quarterly.</i></td> <td data-bbox="1793 266 1887 341">96%</td> </tr> <tr> <td data-bbox="991 341 1087 415">2.</td> <td data-bbox="1087 341 1793 415"><i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i></td> <td data-bbox="1793 341 1887 415">99%</td> </tr> <tr> <td data-bbox="991 415 1087 526">3.</td> <td data-bbox="1087 415 1793 526"><i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i></td> <td data-bbox="1793 415 1887 526">97%</td> </tr> <tr> <td data-bbox="991 526 1087 636">4.</td> <td data-bbox="1087 526 1793 636"><i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i></td> <td data-bbox="1793 526 1887 636">100%</td> </tr> <tr> <td data-bbox="991 636 1087 678">5.</td> <td data-bbox="1087 636 1793 678"><i>Asthma or COPD is addressed in Focus 6 of the WRP.</i></td> <td data-bbox="1793 636 1887 678">97%</td> </tr> <tr> <td data-bbox="991 678 1087 753">6.</td> <td data-bbox="1087 678 1793 753"><i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i></td> <td data-bbox="1793 678 1887 753">97%</td> </tr> <tr> <td data-bbox="991 753 1087 795">7.</td> <td data-bbox="1087 753 1793 795"><i>The individual has been assessed for a flu vaccination.</i></td> <td data-bbox="1793 753 1887 795">92%</td> </tr> <tr> <td data-bbox="991 795 1087 906">8.</td> <td data-bbox="1087 795 1793 906"><i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i></td> <td data-bbox="1793 795 1887 906">91%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for items 1-6. The compliance rates for items 7 and 8 improved from 87% and 85% respectively in the previous period.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>The individual has been evaluated and supporting documentation completed at least quarterly.</i>	96%	2.	<i>For individuals with a diagnosis of COPD, a baseline chest x-ray has been completed.</i>	99%	3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	97%	4.	<i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i>	100%	5.	<i>Asthma or COPD is addressed in Focus 6 of the WRP.</i>	97%	6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	97%	7.	<i>The individual has been assessed for a flu vaccination.</i>	92%	8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	91%
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3.	<i>If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed.</i>	97%																								
4.	<i>If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP.</i>	100%																								
5.	<i>Asthma or COPD is addressed in Focus 6 of the WRP.</i>	97%																								
6.	<i>Focus 6 for Asthma/COPD has appropriate objectives and interventions.</i>	97%																								
7.	<i>The individual has been assessed for a flu vaccination.</i>	92%																								
8.	<i>If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated.</i>	91%																								
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and	Current findings on previous recommendation:																								

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	<p>patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.</p>	<p>Recommendation, December 2009: Develop and implement a formalized system to assess process and clinical outcomes of medical care, utilizing the current monitoring system as well as other relevant data.</p> <p>Findings: During this review period, PSH began to gather both process and clinical outcome data for the current reporting period. The indicators were developed during a meeting between the chiefs of medical services and this monitor. In general, the data demonstrated positive outcomes. The following is a summary outline of the data:</p> <ol style="list-style-type: none"> 1. Process outcomes tracked: <ol style="list-style-type: none"> a. Number of individuals newly diagnosed with diabetes mellitus; b. Number of new diagnoses of diabetes mellitus in individuals receiving new generation antipsychotics; c. Percentage of individuals whose BMI is tracked and documented monthly; d. Measures addressing bowel function in individual receiving clozapine; e. Number of individuals with 3+ falls in 30 days; f. Total number of falls; g. Number of individuals with a diagnosis of aspiration pneumonia; h. Number of individuals with cognitive disorders on old generation anticonvulsants; i. Seizure data; j. Timeliness and appropriateness of external consultations; and k. Review process for unexpected deaths. 2. Clinical outcomes tracked: <ol style="list-style-type: none"> a. Average HA1c value for individuals with diabetes mellitus; b. Average HA1c value for all individuals with diabetes mellitus who also receive new generation antipsychotics; c. Percentage of individuals with dyslipidemia with LDL < 130;
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		<p>d. Percentage of individuals with diabetes mellitus with LDL < 100; e. Average body mass index of individuals with BMI >25; f. Number of individuals with hypertension whose blood pressure is less than 140/90; g. Number of individuals with diabetes mellitus whose blood pressure is less than 130/80; h. Number of individuals hospitalized for bowel dysfunction; i. Individuals with falls with major injury; j. Number of individuals diagnosed with aspiration pneumonia; k. Number of individuals with refractory seizures; l. Number of individuals with status epilepticus; and m. Unexpected mortalities.</p> <p>Some of the above-listed outcomes are reflected in the Key Indicator data presented in the appendix of this report.</p> <p>Additionally, PSH presented the following peer review aggregated data, based on a 100% sample of primary care physicians:</p> <table border="1" data-bbox="991 894 1890 1162"> <tr> <td>1.</td> <td><i>Quality of care</i></td> <td>96%</td> </tr> <tr> <td>2.</td> <td><i>Timeliness of care</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>WRP planning and documentation</i></td> <td>97%</td> </tr> <tr> <td>4.</td> <td><i>Appropriate consultations ordered</i></td> <td>99%</td> </tr> <tr> <td>5.</td> <td><i>Appropriate consultations reviewed</i></td> <td>99%</td> </tr> <tr> <td>6.</td> <td><i>Appropriate labs/diagnostics ordered</i></td> <td>99%</td> </tr> <tr> <td>7.</td> <td><i>Appropriate labs/diagnostics reviewed</i></td> <td>99%</td> </tr> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Quality of care</i>	96%	2.	<i>Timeliness of care</i>	98%	3.	<i>WRP planning and documentation</i>	97%	4.	<i>Appropriate consultations ordered</i>	99%	5.	<i>Appropriate consultations reviewed</i>	99%	6.	<i>Appropriate labs/diagnostics ordered</i>	99%	7.	<i>Appropriate labs/diagnostics reviewed</i>	99%
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6.	<i>Appropriate labs/diagnostics ordered</i>	99%																					
7.	<i>Appropriate labs/diagnostics reviewed</i>	99%																					

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8. Infection Control		
	<p>Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Cindy Blaire, RN 2. Donna Rowe, PHN II 3. Lidia Lau, RN, ACNS 4. Mary Lou Remetir, RN, PHN I 5. Richard Morrissey, MD <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH's progress report and data 2. Department of Medicine meeting minutes for 11/4/09, 12/2/09, 1/14/10, 2/3/10, 3/3/10 and 4/14/10 3. Joint Department of Medicine/Psychiatry meeting minutes dated 2/24/10 4. PSH Enhancement Plan of Action Team Leader meeting minutes dated 12/14/09, 12/15/09, 1/15/10, 2/26/10, 3/26/10 and 4/23/10 5. Infection Control Committee meeting minutes dated 11/12/09, 12/17/09, 1/14/10, 2/18/10, 3/11/10 and 10/8/09 6. Quality Council meeting minutes dated 11/10/09, 12/1/09, 1/12/10, 2/2/10, 3/2/10 and 4/6/10 7. Medical records for the following 93 individuals: AG, AKA, ANA, AS, ASR, BMR, BR, CBA, CBF, CC, CHF, CJT, CL, CMG, CMP, CT-1, CT-2, CWM, DAL, DEB, DP, DSA, EG, EMB, FDL, FJB, FL, GLW, GT, GVC, HAC, HAH, HKV, IRH, JAL, JC, JCM, JDC, JFZ, JG, JHM, JJ, JM, JMM, JP, JPK, JV, JW, JWK, KRE, LD, LJB, LMA, LS, LT, LV, MAS, MM, MS, MVV, NC, OG, PMC, RCG, RD, REF, RHT, RL, RLS, RM, RMT, RTC, RVM, RW, SC, SEJ, SF, SGR, SH, SJH, SL, TM, TN, TO, TS-1, TS-2, UDN, VME, VMG, WC, WKP, WP and YRR 8. PSH Key Indicator data for Infection Control

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8.a	Each State hospital shall establish an effective infection control program that:	Compliance: Partial.															
F.8.a.i	actively collects data regarding infections and communicable diseases;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings (by test/disease):</p> <p><u>Admission PPD</u> Using the DMH IC Admission PPD Audit, PSH assessed its compliance based on an average sample of 72% of individuals admitted to the hospital with a negative PPD in the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 784 1887 1161"> <tr> <td data-bbox="991 784 1087 862">1.</td> <td data-bbox="1087 784 1793 862"><i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 784 1887 862">100%</td> </tr> <tr> <td data-bbox="991 862 1087 940">2.</td> <td data-bbox="1087 862 1793 940"><i>PPDs were ordered by the physician during the admission procedure.</i></td> <td data-bbox="1793 862 1887 940">100%</td> </tr> <tr> <td data-bbox="991 940 1087 1018">3.</td> <td data-bbox="1087 940 1793 1018"><i>PPDs were administered by the nurse within 24 hours of the physicians order.</i></td> <td data-bbox="1793 940 1887 1018">99%</td> </tr> <tr> <td data-bbox="991 1018 1087 1096">4.</td> <td data-bbox="1087 1018 1793 1096"><i>1st step PPDs were read by the nurse within 7 days of administration.</i></td> <td data-bbox="1793 1018 1887 1096">99%</td> </tr> <tr> <td data-bbox="991 1096 1087 1161">5.</td> <td data-bbox="1087 1096 1793 1161"><i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 1096 1887 1161">96%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>	1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the admission procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the physicians order.</i>	99%	4.	<i>1st step PPDs were read by the nurse within 7 days of administration.</i>	99%	5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	96%
1.	<i>Notification by the unit via a PPD form is sent to the Infection Control Department for all PPD readings.</i>	100%															
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5.	<i>2nd step PPDs were read by the nurse within 48-72 hours of administration.</i>	96%															

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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 19 individuals admitted during the review period (BR, CHF, CWM, DP, GLW, IRH, JCM, JHM, JJ, JM, KRE, MVV, OG, RCG, RLS, RVM, SF, TM and VMG) found that all had a physician's order for PPD upon admission and all were timely administered and read.</p> <p><u>Annual PPD</u> Using the DMH IC Annual PPD Audit, PSH assessed its compliance based on an average sample of 29% of individuals needing an annual PPD during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 894 1887 1195"> <tr> <td data-bbox="991 894 1087 971">1.</td> <td data-bbox="1087 894 1793 971"><i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i></td> <td data-bbox="1793 894 1887 971">100%</td> </tr> <tr> <td data-bbox="991 971 1087 1047">2.</td> <td data-bbox="1087 971 1793 1047"><i>PPDs were ordered by the physician during the annual review procedure.</i></td> <td data-bbox="1793 971 1887 1047">100%</td> </tr> <tr> <td data-bbox="991 1047 1087 1123">3.</td> <td data-bbox="1087 1047 1793 1123"><i>PPDs were administered by the nurse within 24 hours of the order.</i></td> <td data-bbox="1793 1047 1887 1123">99%</td> </tr> <tr> <td data-bbox="991 1123 1087 1195">4.</td> <td data-bbox="1087 1123 1793 1195"><i>PPDs were read by the nurse within 48-72 hours of administration.</i></td> <td data-bbox="1793 1123 1887 1195">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p>	1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%	2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%	3.	<i>PPDs were administered by the nurse within 24 hours of the order.</i>	99%	4.	<i>PPDs were read by the nurse within 48-72 hours of administration.</i>	99%
1.	<i>Notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings.</i>	100%												
2.	<i>PPDs were ordered by the physician during the annual review procedure.</i>	100%												
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		<p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 16 individuals requiring an annual PPD during the review period (AG, AKA, ASR, CBA, DEB, EMB, JDC, LT, PMC, RMT, SGR, SH, SL, TN, TO and WKP) found that all had a physician's order for an annual PPD and all annual PPDs were timely given and read.</p> <p><u>Hepatitis C</u> Using the DMH IC Hepatitis C Audit, PSH assessed its compliance based on an average sample of 92% of individuals admitted to the hospital in the review months (November 2009-April 2010) who were positive for Hepatitis C:</p> <table border="1" data-bbox="989 967 1890 1421"> <tr> <td data-bbox="989 967 1087 1081">1.</td> <td data-bbox="1087 967 1793 1081"><i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i></td> <td data-bbox="1793 967 1890 1081">100%</td> </tr> <tr> <td data-bbox="989 1081 1087 1195">2.</td> <td data-bbox="1087 1081 1793 1195"><i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i></td> <td data-bbox="1793 1081 1890 1195">100%</td> </tr> <tr> <td data-bbox="989 1195 1087 1308">3.</td> <td data-bbox="1087 1195 1793 1308"><i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i></td> <td data-bbox="1793 1195 1890 1308">100%</td> </tr> <tr> <td data-bbox="989 1308 1087 1382">4.</td> <td data-bbox="1087 1308 1793 1382"><i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i></td> <td data-bbox="1793 1308 1890 1382">96%</td> </tr> <tr> <td data-bbox="989 1382 1087 1421">5.</td> <td data-bbox="1087 1382 1793 1421"><i>A Focus 6 is opened for Hepatitis C.</i></td> <td data-bbox="1793 1382 1890 1421">98%</td> </tr> </table>	1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%	3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%	4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	96%	5.	<i>A Focus 6 is opened for Hepatitis C.</i>	98%
1.	<i>Notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody.</i>	100%															
2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a positive Hepatitis C Antibody test.</i>	100%															
3.	<i>Hepatitis C Tracking sheet was initiated or the Public Health database was updated for each individual testing positive for Hepatitis C Antibody.</i>	100%															
4.	<i>The individual's medication plan was evaluated and immunizations for Hepatitis A and B were considered.</i>	96%															
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		<table border="1"> <tr> <td data-bbox="978 186 1087 266">6.</td> <td data-bbox="1087 186 1793 266"><i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i></td> <td data-bbox="1793 186 1923 266">99%</td> </tr> <tr> <td data-bbox="978 266 1087 380">7.</td> <td data-bbox="1087 266 1793 380"><i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i></td> <td data-bbox="1793 266 1923 380">96%</td> </tr> </table>	6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	99%	7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	96%	<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 21 individuals who were admitted Hepatitis C positive during the review period (ANA, BMR, CBF, CC, CJT, CMG, CMP, DAL, FJB, FL, HKV, IRH, JV, LD, LS, MM, RD, RM, SEJ, VME and YRR) found that all contained documentation that the medication plan and immunizations were evaluated and had an open Focus 6 for Hepatitis C, and 18 had adequate and appropriate objectives and interventions. Two WRPs (ANA and HKV) were missing critical elements such as prevention of the spread of the disease and one was clinically inappropriate (LD).</p> <p><u>HIV Positive</u> Using the DMH IC HIV Positive Audit, PSH assessed its compliance based on a 100% sample (four individuals) of individuals who were positive for</p>
6.	<i>Appropriate objective is written to include treatment as required by the Hepatitis C Tracking Sheet</i>	99%							
7.	<i>Appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet, or as required by the WRP Manual</i>	96%							

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		<p>HIV antibody in the review months (November 2009-April 2010):</p> <table border="1"> <tr> <td data-bbox="991 264 1087 378">1.</td> <td data-bbox="1087 264 1793 378"><i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i></td> <td data-bbox="1793 264 1887 378">100%</td> </tr> <tr> <td data-bbox="991 378 1087 492">2.</td> <td data-bbox="1087 378 1793 492"><i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i></td> <td data-bbox="1793 378 1887 492">100%</td> </tr> <tr> <td data-bbox="991 492 1087 605">3.</td> <td data-bbox="1087 492 1793 605"><i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i></td> <td data-bbox="1793 492 1887 605">100%</td> </tr> <tr> <td data-bbox="991 605 1087 719">4.</td> <td data-bbox="1087 605 1793 719"><i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i></td> <td data-bbox="1793 605 1887 719">N/A</td> </tr> <tr> <td data-bbox="991 719 1087 865">5.</td> <td data-bbox="1087 719 1793 865"><i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i></td> <td data-bbox="1793 719 1887 865">100%</td> </tr> <tr> <td data-bbox="991 865 1087 906">6.</td> <td data-bbox="1087 865 1793 906"><i>A Focus 6 is opened for HIV (unspecified viral illness)</i></td> <td data-bbox="1793 865 1887 906">100%</td> </tr> <tr> <td data-bbox="991 906 1087 979">7.</td> <td data-bbox="1087 906 1793 979"><i>Appropriate objective is written to address the progression of the disease.</i></td> <td data-bbox="1793 906 1887 979">100%</td> </tr> <tr> <td data-bbox="991 979 1087 1019">8.</td> <td data-bbox="1087 979 1793 1019"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 979 1887 1019">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items that were not N/A in either period.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified. There were no cases of HIV conversion following admission during the review period.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p>	1.	<i>Notification by the lab was made to the infection control department identifying the individual with a positive HIV Antibody.</i>	100%	2.	<i>Notification was made to the unit housing the individual that he/she has a positive HIV Antibody test.</i>	100%	3.	<i>If the individual was admitted with a diagnosis of HIV positive, a referral was made to the appropriate clinic during the admission process.</i>	100%	4.	<i>If the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic.</i>	N/A	5.	<i>The individual is seen initially and followed up, as clinically indicated, by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician.</i>	100%	6.	<i>A Focus 6 is opened for HIV (unspecified viral illness)</i>	100%	7.	<i>Appropriate objective is written to address the progression of the disease.</i>	100%	8.	<i>Appropriate interventions are written.</i>	100%
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		<p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of four individuals who were admitted during the review period with HIV (ANA, FDL, LJB and RL) found that all were in compliance regarding clinic referrals and follow-up and two WRPs contained appropriate objectives and/or interventions (ANA and FDL). One WRP had an open focus addressing HIV; however, the goals and objectives were about Hepatitis C (RL), and one WRP was not in alignment with the individual's cognitive limitations (LB).</p> <p><u>Immunizations</u> Using the DMH IC Immunization Audit, PSH assessed its compliance based on an average sample of 25% of individuals admitted to the hospital during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 930 1887 1269"> <tr> <td data-bbox="991 930 1087 1005">1.</td> <td data-bbox="1087 930 1793 1005"><i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i></td> <td data-bbox="1793 930 1887 1005">100%</td> </tr> <tr> <td data-bbox="991 1005 1087 1079">2.</td> <td data-bbox="1087 1005 1793 1079"><i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i></td> <td data-bbox="1793 1005 1887 1079">100%</td> </tr> <tr> <td data-bbox="991 1079 1087 1154">3.</td> <td data-bbox="1087 1079 1793 1154"><i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i></td> <td data-bbox="1793 1079 1887 1154">100%</td> </tr> <tr> <td data-bbox="991 1154 1087 1269">4.</td> <td data-bbox="1087 1154 1793 1269"><i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i></td> <td data-bbox="1793 1154 1887 1269">97%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of an individual's immunity status.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual of his/her immunity status.</i>	100%	3.	<i>Immunizations were ordered by the physician within 30 days of receiving notification by the lab.</i>	100%	4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	97%
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4.	<i>Immunizations were administered by the nurse within 24 hours of the physician order and completed within timeframes.</i>	97%												

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		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 19 individuals (BR, CHF, CWM, DP, GLW, IRH, JCM, JHM, JJ, JM, KRE, MVV, OG, RCG, RLS, RVM, SF, TM and VMG) found that all contained documentation that the immunizations were ordered by the physician within 60 days of receiving notification by the lab and all ordered immunizations were timely administered.</p> <p><u>Immunization Refusals</u> Using the DMH IC Immunization Refusal Audit, PSH assessed its compliance based on a 100% sample (54 individuals) of individuals in the hospital who refused to take their immunizations during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="989 1078 1887 1414"> <tr> <td data-bbox="989 1078 1087 1190">1.</td> <td data-bbox="1087 1078 1793 1190"><i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i></td> <td data-bbox="1793 1078 1887 1190">100%</td> </tr> <tr> <td data-bbox="989 1190 1087 1268">2.</td> <td data-bbox="1087 1190 1793 1268"><i>There is a Focus 6 opened for the refusal of the immunization(s).</i></td> <td data-bbox="1793 1190 1887 1268">98%</td> </tr> <tr> <td data-bbox="989 1268 1087 1346">3.</td> <td data-bbox="1087 1268 1793 1346"><i>There are appropriate objective(s) developed for the refusal of immunization(s).</i></td> <td data-bbox="1793 1268 1887 1346">98%</td> </tr> <tr> <td data-bbox="989 1346 1087 1414">4.</td> <td data-bbox="1087 1346 1793 1414"><i>There are appropriate interventions written for the objective(s) developed for the refusal of</i></td> <td data-bbox="1793 1346 1887 1414">94%</td> </tr> </table>	1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%	2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	98%	3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	98%	4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of</i>	94%
1.	<i>Notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s)</i>	100%												
2.	<i>There is a Focus 6 opened for the refusal of the immunization(s).</i>	98%												
3.	<i>There are appropriate objective(s) developed for the refusal of immunization(s).</i>	98%												
4.	<i>There are appropriate interventions written for the objective(s) developed for the refusal of</i>	94%												

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		<table border="1"> <tr> <td data-bbox="989 188 1087 228"></td> <td data-bbox="1087 188 1793 228"><i>immunization(s).</i></td> <td data-bbox="1793 188 1890 228"></td> </tr> <tr> <td data-bbox="989 228 1087 342">5.</td> <td data-bbox="1087 228 1793 342"><i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i></td> <td data-bbox="1793 228 1890 342">98%</td> </tr> </table>		<i>immunization(s).</i>		5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	98%	
	<i>immunization(s).</i>								
5.	<i>The unit notified the Infection Control Department when the individual consented and received the immunization(s).</i>	98%							
<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 10 individuals who refused immunizations during the review period (CMG, DSA, HAC, JG, JW, REF, RTC, SC, SJH and TS-1) found that all WRPs contained an open Focus 6 and four contained appropriate objectives and interventions (DSA, JG, JW and SC). Five WRPs were not individualized and only contained the template for refusals with no reason for the refusal stated to guide the goals and interventions. One WRP (HAC) had an open focus for refusal of Hepatitis B Vaccine; however the intervention addressed a hernia repair.</p> <p><u>MRSA</u> Using the DMH IC MRSA Audit, PSH assessed its compliance based on a 75% sample (24 individuals) of individuals in the hospital who tested positive for MRSA during the review months (November 2009-April</p>									

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		<p>2010):</p> <table border="1"> <tr> <td data-bbox="991 266 1087 378">1.</td> <td data-bbox="1087 266 1793 378"><i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i></td> <td data-bbox="1793 266 1887 378">100%</td> </tr> <tr> <td data-bbox="991 378 1087 490">2.</td> <td data-bbox="1087 378 1793 490"><i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i></td> <td data-bbox="1793 378 1887 490">100%</td> </tr> <tr> <td data-bbox="991 490 1087 570">3.</td> <td data-bbox="1087 490 1793 570"><i>The individual is placed on contact precaution per MRSA policy.</i></td> <td data-bbox="1793 490 1887 570">100%</td> </tr> <tr> <td data-bbox="991 570 1087 646">4.</td> <td data-bbox="1087 570 1793 646"><i>The appropriate antibiotic was ordered for treatment of the infection(s).</i></td> <td data-bbox="1793 570 1887 646">100%</td> </tr> <tr> <td data-bbox="991 646 1087 758">5.</td> <td data-bbox="1087 646 1793 758"><i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i></td> <td data-bbox="1793 646 1887 758">100%</td> </tr> <tr> <td data-bbox="991 758 1087 797">6.</td> <td data-bbox="1087 758 1793 797"><i>A Focus 6 is opened for MRSA.</i></td> <td data-bbox="1793 758 1887 797">100%</td> </tr> <tr> <td data-bbox="991 797 1087 873">7.</td> <td data-bbox="1087 797 1793 873"><i>Appropriate objective is written to include prevention of spread of infection</i></td> <td data-bbox="1793 797 1887 873">100%</td> </tr> <tr> <td data-bbox="991 873 1087 950">8.</td> <td data-bbox="1087 873 1793 950"><i>Appropriate interventions are written to include contact precautions.</i></td> <td data-bbox="1793 873 1887 950">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p>	1.	<i>Notification by the lab was made to the Infection Control Department when an individual has a positive culture for MRSA.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that a positive culture for MRSA was obtained</i>	100%	3.	<i>The individual is placed on contact precaution per MRSA policy.</i>	100%	4.	<i>The appropriate antibiotic was ordered for treatment of the infection(s).</i>	100%	5.	<i>The public health office contacts the unit RN and provides MRSA protocol and guidance for the care of the individual.</i>	100%	6.	<i>A Focus 6 is opened for MRSA.</i>	100%	7.	<i>Appropriate objective is written to include prevention of spread of infection</i>	100%	8.	<i>Appropriate interventions are written to include contact precautions.</i>	100%
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		<p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of 11 individuals with MRSA (CT-1, HAH, JP, JW, JWK, LMA, MAS, RHT, RW, WC and WP) found that all individuals were placed on contact precautions and on the appropriate antibiotic. Two WRPs did not contain appropriate objectives and interventions (JW and RW).</p> <p><u>Positive PPD</u> Using the DMH IC Positive PPD Audit, PSH assessed its compliance based on an average sample of 100% of individuals in the hospital who had a positive PPD test during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 711 1890 1274"> <tr> <td>1.</td> <td><i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>All positive PPDs received PA and Lateral Chest X-ray.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>All positive PPDs received an evaluation by the Med-Surg Physician.</i></td> <td>100%</td> </tr> <tr> <td>4.</td> <td><i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i></td> <td>N/A</td> </tr> <tr> <td>5.</td> <td><i>If LTBI is present, there is a Focus 6 opened.</i></td> <td>100%</td> </tr> <tr> <td>6.</td> <td><i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i></td> <td>100%</td> </tr> <tr> <td>7.</td> <td><i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 4 was not applicable in either period).</p>	1.	<i>Notification by the unit via a PPD form is sent to Public Health Office for all PPD readings.</i>	100%	2.	<i>All positive PPDs received PA and Lateral Chest X-ray.</i>	100%	3.	<i>All positive PPDs received an evaluation by the Med-Surg Physician.</i>	100%	4.	<i>If active disease is identified, then individual is transferred to medical isolation and appropriate treatment is provided.</i>	N/A	5.	<i>If LTBI is present, there is a Focus 6 opened.</i>	100%	6.	<i>If LTBI is present, there are appropriate objectives written to provide treatment and to prevent spread of the disease.</i>	100%	7.	<i>If LTBI is present, there are appropriate interventions written to prevent the progression of the disease.</i>	100%
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		<p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified. There were no cases of PPD conversion following admission to the facility or any cases of active TB during the review period.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of nine individuals who had a positive PPD (AS, GT, GVC, JAL, JMM, JPK, MS, OG and TN) found that all individuals had the required chest x-rays, and all records contained documentation of an evaluation from the physician. Three WRPs contained appropriate objectives and interventions (GT, JPK and OG). The remaining six WRPs were not individualized and contained only the template developed by infection control (AS, GVC, JAL, JMM, MS and TN).</p> <p><u>Refusal of Admitting or Annual Lab Work or Diagnostic Tests</u> Using the DMH IC DMH IC Refused Admitting or Annual Lab Work or Diagnostic Test Audit, PSH assessed its compliance based on a 100% sample of individuals in the hospital who refused their admission lab work, admission PPD, or annual PPD during the review months (November 2009- April 2010):</p> <table border="1" data-bbox="989 1300 1890 1412"> <tr> <td data-bbox="989 1300 1081 1412">1.</td> <td data-bbox="1081 1300 1793 1412"><i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control</i></td> <td data-bbox="1793 1300 1890 1412">100%</td> </tr> </table>	1.	<i>Notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD, is sent to the Infection Control</i>	100%
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		<table border="1"> <tr> <td></td> <td><i>Department.</i></td> <td></td> </tr> <tr> <td>2.</td> <td><i>There is a Focus opened for the lab work or PPD refusal</i></td> <td>98%</td> </tr> <tr> <td>3.</td> <td><i>There are appropriate objectives written for the lab work or PPD refusal.</i></td> <td>96%</td> </tr> <tr> <td>4.</td> <td><i>There are appropriate interventions written for the lab work or PPD refusal.</i></td> <td>96%</td> </tr> </table>		<i>Department.</i>		2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	98%	3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	96%	4.	<i>There are appropriate interventions written for the lab work or PPD refusal.</i>	96%	<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p> <p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of nine individuals who refused admitting or annual labs/diagnostics (CL, CT-2, JC, JFZ, LV, MM, TS-2, UDN and WC) found that five refusals were not adequately addressed in the WRPs (CL, JC, JFZ, LV and MM). These five WRPs were not individualized as to why the individuals refused the procedures and contained the identical templates for refusals.</p> <p><u>Sexually Transmitted Diseases</u> Using the DMH IC Sexually Transmitted Disease (STD) Audit, PSH assessed its compliance based on a 100% sample of individuals in the</p>
	<i>Department.</i>														
2.	<i>There is a Focus opened for the lab work or PPD refusal</i>	98%													
3.	<i>There are appropriate objectives written for the lab work or PPD refusal.</i>	96%													
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		<p>hospital who tested positive for an STD during the review months (November 2009-April 2010):</p> <table border="1"> <tr> <td data-bbox="991 305 1087 380">1.</td> <td data-bbox="1087 305 1793 380"><i>Notification by the lab was made to the Infection Control Department of a positive STD.</i></td> <td data-bbox="1793 305 1887 380">100%</td> </tr> <tr> <td data-bbox="991 380 1087 454">2.</td> <td data-bbox="1087 380 1793 454"><i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i></td> <td data-bbox="1793 380 1887 454">100%</td> </tr> <tr> <td data-bbox="991 454 1087 529">3.</td> <td data-bbox="1087 454 1793 529"><i>An RPR is ordered during the admission process for each individual.</i></td> <td data-bbox="1793 454 1887 529">100%</td> </tr> <tr> <td data-bbox="991 529 1087 604">4.</td> <td data-bbox="1087 529 1793 604"><i>An HIV antibody test is offered to every individual upon admission.</i></td> <td data-bbox="1793 529 1887 604">100%</td> </tr> <tr> <td data-bbox="991 604 1087 678">5.</td> <td data-bbox="1087 604 1793 678"><i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i></td> <td data-bbox="1793 604 1887 678">100%</td> </tr> <tr> <td data-bbox="991 678 1087 753">6.</td> <td data-bbox="1087 678 1793 753"><i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i></td> <td data-bbox="1793 678 1887 753">N/A</td> </tr> <tr> <td data-bbox="991 753 1087 828">7.</td> <td data-bbox="1087 753 1793 828"><i>Focus 6 is opened for an individual testing positive for an STD.</i></td> <td data-bbox="1793 753 1887 828">100%</td> </tr> <tr> <td data-bbox="991 828 1087 867">8.</td> <td data-bbox="1087 828 1793 867"><i>Appropriate objective(s) are written.</i></td> <td data-bbox="1793 828 1887 867">100%</td> </tr> <tr> <td data-bbox="991 867 1087 906">9.</td> <td data-bbox="1087 867 1793 906"><i>Appropriate interventions are written.</i></td> <td data-bbox="1793 867 1887 906">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items (item 6 was not applicable in either period).</p> <p><u>F.8.a.ii: Assesses these data for trends</u> No problematic trends were identified. All individuals who were positive for a STD were found at the time of their admission to the facility.</p> <p><u>F.8.a.iii: Initiates inquiries regarding problematic trends</u> None required.</p> <p><u>F.8.a.iv: Identifies necessary corrective action</u> No corrective action was needed.</p>	1.	<i>Notification by the lab was made to the Infection Control Department of a positive STD.</i>	100%	2.	<i>Notification by the lab was made to the unit housing the individual that he/she has a STD.</i>	100%	3.	<i>An RPR is ordered during the admission process for each individual.</i>	100%	4.	<i>An HIV antibody test is offered to every individual upon admission.</i>	100%	5.	<i>A Chlamydia and Gonorrhea test are ordered during the admission process for all female individuals</i>	100%	6.	<i>If the individual was involved in a sexual incident, he/she was offered appropriate STD testing.</i>	N/A	7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%	8.	<i>Appropriate objective(s) are written.</i>	100%	9.	<i>Appropriate interventions are written.</i>	100%
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7.	<i>Focus 6 is opened for an individual testing positive for an STD.</i>	100%																											
8.	<i>Appropriate objective(s) are written.</i>	100%																											
9.	<i>Appropriate interventions are written.</i>	100%																											

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		<p><u>F.8.a.v: Monitors to ensure that appropriate remedies are achieved</u> PSH will continue to monitor this requirement.</p> <p>A review of the records of four individuals with diagnosed STDs (EG, JC, NC and SC) found that the appropriate lab work indicating a positive STD was obtained in all cases and the STD was adequately addressed in the WRP in none of the four cases.</p> <p>Findings from the review of WRPs in a number of areas described above demonstrated slippage from the last review and did not comport with PSH's data. The Infection Control liaison reported that in some cases, the original WRPs were audited by Standards Compliance and were found in compliance and then inappropriately modified. In a number of cases, especially regarding refusals, there was no indication that the individuals were asked why they were refusing a particular procedure in order to guide the goals and interventions specifically to each individual's needs. Also, in a number of cases, a template was used in the WRP without modifications specific to the individual. For example, a number of PPD positive WRPs stated that "if" the individual was being treated with INH, then the individual should be educated as to the side effects of the medication. At the time of the review, the WRPTs should know if the individual is being treated with INH and modify the template accordingly. Nursing needs to collaborate with Infection Control since issues with the WRPs appear to be at the unit nursing level.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that there is continued collaboration between the Infection Control Department and nursing regarding WRPs addressing infection control issues.
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		2. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Implement system to ensure reliability of IC Key Indicator data and review by the Infection Control Department. • Continue to monitor this requirement. <p>Findings:</p> <p>A review of PSH's Key Indicator data for Hepatitis C found that it was different than the data presented in PSH's progress report. Specifically, the Key Indicator data for Hepatitis C showed that there was one new diagnosis between January 2008 and October 2009 and then between November 2009 and April 2010 there were 70 new diagnoses. The Infection Control Department reported that it provides the numbers for infection control items to Standards Compliance and was not aware of what was reported in the Key Indicator data. The Medical Risk Management Committee Coordinator was interviewed regarding this issue and indicated that Standards Compliance was now reporting the total number of individuals who were admitted to the facility with an existing diagnosis of Hepatitis C as well as any cases of hospital-acquired Hepatitis C versus only new hospital acquired cases of Hepatitis C. At the time of the review, the Infection Control Department was not aware of the change in reporting cases of Hepatitis C in the Key Indicator data. The facility needs to ensure that Key Indicator data for Infection Control is reviewed by the Infection Control Department and that changes in data collection methodology are shared between departments. The facility should be in substantial compliance with this requirement by the next review.</p> <p>Compliance: Partial.</p>

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		<p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Ensure that Key Indicator data for Infection Control is reviewed by the Infection Control and changes in data collection methodology are shared between departments. 2. Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.iv	identifies necessary corrective action;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p>

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		<p>Current recommendation: Continue current practice.</p>
F.8.a.v	<p>monitors to ensure that appropriate remedies are achieved; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: See F.8.a.i.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.8.a.vi	<p>integrates this information into each State hospital's quality assurance review.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Review of the minutes of PSH's meetings verified that IC data are discussed monthly at the meetings of the Infection Control Committee, the Joint Department of Medicine and Psychiatry, the Department of Medicine and the Enhancement Plan Committee.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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9. Dental Services		
	<p>Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. Amy Santimalapong, DDS, Chief Dentist 2. Kathryn Smith, RN, Nurse Auditor 3. George Christison, MD, Acting Medical Director <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH's progress report and data 2. PSH's dental appointment logs 3. Medical records for the following 101 individuals: AC, AG, AKA, ALM, ASR, BBD, BC, BE, BK, BR, BRA, CAL, CB, CBA, CHF, COP, CR, CS, CTM, CWM, DAJ, DEB, DF, DP, DU, DW, EDW, EK, EMB, ER, EWA, FB, GA, GL, GLW, GPG, HLE, HLM, HMP, IRH, JCG, JCM, JDC, JEM, JHC, JHM, JJ, JM, JOG, KA, KMC, KRE, LLF, LMP, LT, LWS, MCP, MLB, MN, MV, MVV, NM, OG, OR, PCJ, PMC, RC, RCG-1, RCG-2, RLL, RLS, RM, RMT, RNB, RPY, RVM, RXA, SA, SAL, SF, SGR, SH, SJ, SKO, SL, SMC, TD, TH, THH, TJM, TM, TMH, TMM, TN, TO, VMG, WHS, WKP, WL, WT and YCO 4. Nursing Policy and Procedure 500-A; Refusal of Medical Care System (draft)
F.9.a	<p>Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Pursue recommendations included in the 2009/2010 Budget Change Proposal. • Continue to monitor this requirement. <p>Findings:</p> <p>The number of full-time dental staff remained unchanged from the last reporting period.</p>

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		<p>PSH's Chief Dentist submitted a Budget Change Proposal to PSH's Executive Director in May 2009 that included requests for the expansion of the dental clinics, office space, and the addition of dental staff to include two dentists, two dental hygienists and three dental assistants. In September 2009, the Executive Director approved a part-time student assistant position for data entry, which has freed up the dental clinical staff from this duty. In October 2009, the Executive Director approved a part-time position for a dentist working 20-24 hours per week. Three applicants were interviewed on 12/04/09 and 14 more candidates were interviewed in January 2010. A candidate was selected but unfortunately declined the position. PSH continues its efforts in pursuing hiring for the Dentist position. Although PSH has not yet filled the part-time dental position, they have achieved substantial compliance with the exception of F.9.e (refusals).</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	<p>Compliance: Substantial.</p>
F.9.b.i	comprehensive and timely provision of dental services;	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to implement strategies to increase compliance with this requirement. • Continue to monitor this requirement.

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		<p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 56% mean sample of individuals scheduled for comprehensive dental exams during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 375 1887 415"> <tr> <td data-bbox="991 375 1087 415">1.a</td> <td data-bbox="1087 375 1793 415"><i>Comprehensive dental exam was completed</i></td> <td data-bbox="1793 375 1887 415">96%</td> </tr> </table> <p>Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 19 individuals (BR, CHF, CWM, DP, GLW, IRH, JCM, JHM, JJ, JM, KRE, MVV, OG, RCG-1, RLS, RVM, SF, TM and VMG) found all 19 individuals received a comprehensive dental exam.</p> <p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 48% mean sample of individuals who have been in the hospital for 90 days or less during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 898 1887 938"> <tr> <td data-bbox="991 898 1087 938">1.b</td> <td data-bbox="1087 898 1793 938"><i>If admission examination date was 90 days or less</i></td> <td data-bbox="1793 898 1887 938">94%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 77% in the previous review period.</p> <p>A review of the records of 19 individuals (BR, CHF, CWM, DP, GLW, IRH, JCM, JHM, JJ, JM, KRE, MVV, OG, RCG-1, RLS, RVM, SF, TM and VMG) found that all 19 individuals were timely seen for their admission exams.</p> <p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 22% mean sample of individuals due for annual routine dental examinations during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 1382 1887 1422"> <tr> <td data-bbox="991 1382 1087 1422">1.c</td> <td data-bbox="1087 1382 1793 1422"><i>Annual date of examination was within anniversary</i></td> <td data-bbox="1793 1382 1887 1422">96%</td> </tr> </table>	1.a	<i>Comprehensive dental exam was completed</i>	96%	1.b	<i>If admission examination date was 90 days or less</i>	94%	1.c	<i>Annual date of examination was within anniversary</i>	96%
1.a	<i>Comprehensive dental exam was completed</i>	96%									
1.b	<i>If admission examination date was 90 days or less</i>	94%									
1.c	<i>Annual date of examination was within anniversary</i>	96%									

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 191 1890 230"> <tr> <td data-bbox="991 191 1087 230"></td> <td data-bbox="1087 191 1793 230"><i>month of admission</i></td> <td data-bbox="1793 191 1890 230"></td> </tr> </table> <p data-bbox="991 272 1879 341">Comparative data indicated improvement in compliance from 80% in the previous review period.</p> <p data-bbox="991 383 1906 488">A review of the records of 17 individuals (AG, AKA, ASR, CBA, DEB, EMB, JDC, LT, PMC, RCG-2, RMT, SGR, SH, SL, TN, TO and WKP) found that 16 annual exams were timely completed.</p> <p data-bbox="991 531 1892 672">Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals with dental problems identified on admission or annual examination during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 711 1890 824"> <tr> <td data-bbox="991 711 1087 824">1.d</td> <td data-bbox="1087 711 1793 824"><i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i></td> <td data-bbox="1793 711 1890 824">100%</td> </tr> </table> <p data-bbox="991 867 1885 935">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 977 1906 1154">A review of the records of 36 individuals (AG, AKA, ASR, BR, CBA, CHF, CWM, DEB, DP, EMB, GLW, IRH, JCM, JDC, JHM, JJ, JM, KRE, LT, MVV, OG, PMC, RCG-1, RCG-2, RLS, RMT, RVM, SF, SGR, SH, SL, TM, TN, TO, VMG and WKP) found that all individuals were timely seen for follow-up care.</p> <p data-bbox="991 1196 1829 1338">Using the DMH Dental Services Audit, PSH assessed its compliance based on a 68% mean sample of individuals with dental problems identified other than on admission or annual examination during the review months (November 2009-April 2010):</p>		<i>month of admission</i>		1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%
	<i>month of admission</i>							
1.d	<i>Individuals with identified problems on admission or annual examination receive follow up care, as indicated, in a timely manner</i>	100%						

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		<table border="1" data-bbox="991 191 1900 342"> <tr> <td data-bbox="991 191 1087 342">1.e</td> <td data-bbox="1087 191 1795 342"><i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i></td> <td data-bbox="1795 191 1900 342">100%</td> </tr> </table> <p data-bbox="991 386 1900 451">Comparative data indicated that PSH maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 495 1900 602">A review of the records of 15 individuals (AC, ALM, BC, BK, EDW, ER, GL, KA, KMC, RC, RPY, SJ, SKO, TMH and WT) found that 15 individuals received timely follow-up care.</p> <p data-bbox="991 646 1900 711">Current recommendation: Continue to monitor this requirement.</p>	1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%
1.e	<i>Individuals with identified problems during their hospital stay, other than on admission or annual examination, receive follow-up care, as indicated, in a timely manner</i>	100%			
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	<p data-bbox="991 760 1900 792">Current findings on previous recommendation:</p> <p data-bbox="991 836 1900 901">Recommendation, December 2009: Continue to monitor this requirement.</p> <p data-bbox="991 945 1900 1084">Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 29% mean sample of individuals scheduled for follow-up dental care during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 1128 1900 1235"> <tr> <td data-bbox="991 1128 1087 1235">2.</td> <td data-bbox="1087 1128 1795 1235"><i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i></td> <td data-bbox="1795 1128 1900 1235">99%</td> </tr> </table> <p data-bbox="991 1279 1900 1344">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="991 1388 1900 1416">A review of dental documentation for 37 individuals (AG, AKA, ASR, BR,</p>	2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	99%
2.	<i>Documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care.</i>	99%			

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		<p>CBA, CHF, CWM, DEB, DP, EMB, GLW, IRH, JCM, JDC, JHM, JJ, JM-1, JM-2, KRE, LT, MVV, OG, PMC, RCG-1, RCG-2, RLS, RMT, RVM, SF, SGR, SH, SL, TM, TN, TO, VMG and WKP) found compliance with the documentation requirements in 37 cases.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.9.b.iii	use of preventive and restorative care whenever possible; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 10% mean sample of individuals due for annual routine dental examinations during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="993 857 1887 971"> <tr> <td data-bbox="993 857 1087 971">3.a</td> <td data-bbox="1087 857 1793 971"><i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application, and oral hygiene instruction</i></td> <td data-bbox="1793 857 1887 971">100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 16 individuals (CAL, DF, DW, EK, FB, GA, HLE, JEM, JOG, OG, RM, RNB, RXA, THH, TJM and WHS) found that 16 individuals were provided preventive care.</p> <p>Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals scheduled for Level 1 restorative care during the review months (November 2009-April 2010):</p>	3.a	<i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application, and oral hygiene instruction</i>	100%
3.a	<i>Preventive care was provided, including but not limited to cleaning, root planning, sealant, fluoride application, and oral hygiene instruction</i>	100%			

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		<table border="1" data-bbox="993 196 1900 269"> <tr> <td data-bbox="993 196 1087 269">3.c</td> <td data-bbox="1087 196 1793 269"><i>Restorative care was provided including permanent or temporary restorations (fillings)</i></td> <td data-bbox="1793 196 1900 269">100%</td> </tr> </table> <p data-bbox="993 313 1900 378">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p data-bbox="993 422 1900 524">A review of the records of 13 individuals (BE, BRA, CTM, DU, EWA, GPG, HMP, LLF, MCP, MLB, OR, RMT and TD) found that all 13 individuals were provided restorative care.</p> <p data-bbox="993 568 1900 638">Current recommendation: Continue to monitor this requirement.</p>	3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%
3.c	<i>Restorative care was provided including permanent or temporary restorations (fillings)</i>	100%			
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	<p data-bbox="993 686 1900 719">Current findings on previous recommendation:</p> <p data-bbox="993 756 1900 821">Recommendation, December 2009: Continue current practice.</p> <p data-bbox="993 865 1900 1011">Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 97% mean sample of individuals who had tooth extractions during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="993 1049 1900 1308"> <tr> <td data-bbox="993 1049 1087 1308">4.</td> <td data-bbox="1087 1049 1793 1308"><i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i></td> <td data-bbox="1793 1049 1900 1308">100%</td> </tr> </table> <p data-bbox="993 1352 1900 1417">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p>	4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	100%
4.	<i>Tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review. Periodontal conditions, requirement for denture construction, non-restorable tooth or severe decay or if none of the above reasons is included, other reason stated is clinically appropriate.</i>	100%			

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		<p>A review of the records of 21 individuals (ASR, BBD, COP, CS, DEB, HLM, JCG, JHC, MN, MV, NM, PCJ, RLL, SA, SAL, SMC, TH, TO, WKP, WL and YCO) found that all 21 records were in compliance with this requirement.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.9.c	<p>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample of individuals who received comprehensive dental examinations or follow-up dental care during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="993 898 1890 1083"> <tr> <td data-bbox="993 898 1087 1083">5.</td> <td data-bbox="1087 898 1795 1083"><i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i></td> <td data-bbox="1795 898 1890 1083">99%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of the records of 37 individuals (AG, AKA, ASR, BR, CBA, CHF, CWM, DEB, DP, EMB, GLW, IRH, JCM, JDC, JHM, JJ, JM-1, JM-2, KRE, LT, MVV, OG, PMC, RCG-1, RCG-2, RLS, RMT, RVM, SF, SGR, SH, SL, TM, TN, TO, VMG and WKP) found that all 37 records were in compliance with the documentation requirements.</p>	5.	<i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i>	99%
5.	<i>Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.</i>	99%			

Section F: Specific Therapeutic and Rehabilitation Services

		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>			
F.9.d	<p>Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Implement strategies addressing dental refusals.</p> <p>Findings: See F.9.e</p> <p>Recommendation 2, December 2009: Continue to monitor this requirement.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% mean sample of individuals scheduled for dental appointments during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="991 1042 1887 1192"> <tr> <td data-bbox="991 1042 1087 1192">6.a</td> <td data-bbox="1087 1042 1793 1192"><i>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.</i></td> <td data-bbox="1793 1042 1887 1192">98%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>The facility provided the following data on missed appointments:</p>	6.a	<i>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.</i>	98%
6.a	<i>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.</i>	98%			

Section F: Specific Therapeutic and Rehabilitation Services

		Month	Refused to come to appt	Unit staff procedural problem	Transportation problem			
		11/09	94	1	0			
		12/09	98	6	0			
		1/10	103	5	3			
		2/10	121	1	3			
		3/10	143	6	6			
		4/10	78	7	5			
		<p>A review of the Dental appointment logs verified that the majority of missed appointments were due to refusals, not to transportation or staffing issues.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>						
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: See F.9.d.</p> <p>Findings: Using the DMH Dental Services Audit, PSH assessed its compliance based on a 100% sample (12 individuals) of individuals scheduled for but refusing to attend dental appointments during the review months (November 2009-April 2010):</p> <table border="1" data-bbox="993 1349 1887 1424"> <tr> <td data-bbox="993 1349 1087 1424">7.</td> <td data-bbox="1087 1349 1793 1424"><i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to</i></td> <td data-bbox="1793 1349 1887 1424">100%</td> </tr> </table>				7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to</i>	100%
7.	<i>Each state hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to</i>	100%						

Section F: Specific Therapeutic and Rehabilitation Services

		<table border="1" data-bbox="991 191 1885 266"> <tr> <td data-bbox="991 191 1087 266"></td> <td data-bbox="1087 191 1793 266"><i>overcome individual's refusals to participate in dental appointments</i></td> <td data-bbox="1793 191 1885 266"></td> </tr> </table> <p data-bbox="991 310 1860 375">Comparative data indicated improvement in compliance from 4% in the previous review period.</p> <p data-bbox="991 420 1885 634">A review of PSH's data regarding the number of individuals who refused their dental appointments each month during the review period (see F.9.d) indicated that there was a significant discrepancy between that data and the sample (12 individuals) reflected in the table above. The Medical Director reported that the system addressing refusals has not yet been fully implemented, but will include the following process:</p> <ul data-bbox="991 680 1904 1227" style="list-style-type: none"> • All medical appointment outcome data (internal and external medical appointments) are to be provided to the Quality Council for review. • A Corrective Action Team (CAT) was developed to address hospital-wide appointment refusals, including dental refusals. The CAT is led by Jim Birks, NC. • The CAT is currently developing strategies to reduce refusals and address barriers to individuals attending their medical appointments. • Each month, the CAT will provide data to the Quality Council to determine if strategies implemented have been successful in reducing refusals. • A High Risk Refusal Protocol was implemented in November 2009. • For High Risk Refusals, the treating psychologist will have one week to complete an evaluation as to the causes and barriers relevant to the refusal and will formulate a plan accordingly. • The audits are being conducted on High Risk refusals only. <p data-bbox="991 1273 1885 1411">A review of the records of eight individuals that the facility reported had been designated as high risk for their refusal (CB, DAJ, EMB, LMP, LWS, SF, TD and TMM) found that none of the individuals had been assessed by the a psychologist. Three records contained documentation</p>		<i>overcome individual's refusals to participate in dental appointments</i>	
	<i>overcome individual's refusals to participate in dental appointments</i>				

Section F: Specific Therapeutic and Rehabilitation Services

		<p>that the individual was seen by the dentist (EMB, LWS and TMM); three records had an open focus addressing refusals (CB, LMP and TD); and two records did not have an open focus addressing refusals (DAJ and SF). There was no indication from the documentation contained in the WRPs that any of the nine individuals were deemed high risk for their refusals. These findings do not comport with PSH's data. The facility needs to continue to develop and implement a system addressing this requirement that includes a system to track this specific population.</p> <p>Compliance: Partial.</p> <p>Current recommendations:</p> <ol style="list-style-type: none">1. Continue to develop and implement a system addressing this requirement that includes a system to track this specific population.2. Continue to monitor this requirement.
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Section G: Documentation

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

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

H. Restraints, Seclusion, and PRN and Stat Medication		
H		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. PSH has attained substantial compliance with the requirements of this Section. 2. PSH continues to be committed to decreasing the use of restraint and seclusion and has made significant progress in this area since the last review. 3. PSH has made significant progress regarding the documentation requirements for seclusion and restraint.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. George Christison, MD, Acting Medical Director 2. Harry Oreol, Program Director 3. Lidia Lau, RN, Assistant Coordinator Nursing Services <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. PSH's progress report and data 2. PSH training rosters 3. Medical records of the following 27 individuals: AH, ALA, DB, DLG, DLR, FJ, GDM, GH, JEP, JGC, JH, JS, KA, KDP, LMM, LS, MF, MSB, MW, NM, PEG, RPJ, SA, SWK, TMM, TMO and VF
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	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: No incidents of prone restraint, containment or transportation were found during this review.</p>

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

	<p>shall list the types of restraints that are acceptable for use.</p>	<p>Other findings: A review of Restraint/Seclusion data from the initial review period of November 2006 to April 2007 to the current review period indicated PSH's overall positive efforts regarding the use of these restrictive measures as follows:</p> <ul style="list-style-type: none"> • Mean duration hour of restraint decreased from 6.51 to 3.25 (50% reduction); • Mean duration hours of seclusion decreased from 3.71 to 1.96 (47% reduction); • Mean monthly hours of restraint decreased from 485.22 to 128.85 (73% reduction); • Mean monthly hours of seclusion decreased from 4.33 to 0.98 (77% reduction); • Mean number of restraint events decreased from 74.50 to 39.67 (47% reduction); and • Mean number of seclusion events decreased from 1.17 to 0.50 (57% reduction). <p>During this time, the average daily census increased by 1% from 1500 to 1513, so the reductions noted above are not the result of changes in the overall census.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
<p>H.2</p>	<p>Each State hospital shall ensure that restraints and seclusion:</p>	<p>Compliance: Substantial.</p>

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

<p>H.2.a</p>	<p>are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: PSH initiated the new DMH Physician Order for Behavioral Seclusion or Restraint Form and DMH Observation Record for Behavioral Seclusion or Restraint Form during the review period.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample (seven episodes) of initial seclusion orders each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 711 1890 938"> <tr> <td>1.</td> <td><i>Seclusion is used in a documented manner.</i></td> <td>100%</td> </tr> <tr> <td>2.</td> <td><i>Seclusion is used only when the individual posed an imminent danger to self or others.</i></td> <td>100%</td> </tr> <tr> <td>3.</td> <td><i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td>100%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p>A review of three episodes of seclusion for two individuals (AH and MSB) found that the documentation for all episodes supported the decision to place the individual in seclusion. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample (a total of 238 episodes) of initial restraint orders each month during the review period (November 2009-April 2010):</p>	1.	<i>Seclusion is used in a documented manner.</i>	100%	2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%
1.	<i>Seclusion is used in a documented manner.</i>	100%									
2.	<i>Seclusion is used only when the individual posed an imminent danger to self or others.</i>	100%									
3.	<i>Seclusion is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	100%									

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		<table border="1" data-bbox="991 228 1887 456"> <tr> <td data-bbox="991 228 1087 266">1.</td> <td data-bbox="1087 228 1793 266"><i>Restraint is used in a documented manner.</i></td> <td data-bbox="1793 228 1887 266">98%</td> </tr> <tr> <td data-bbox="991 266 1087 342">2.</td> <td data-bbox="1087 266 1793 342"><i>Restraint is used only when the individual posed an imminent danger to self or others.</i></td> <td data-bbox="1793 266 1887 342">100%</td> </tr> <tr> <td data-bbox="991 342 1087 456">3.</td> <td data-bbox="1087 342 1793 456"><i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i></td> <td data-bbox="1793 342 1887 456">99%</td> </tr> </table> <p data-bbox="991 500 1902 565">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 609 1902 824">A review of 32 episodes of restraint for 25 individuals (ALA, DB, DLG, DLR, FJ, GDM, GH, JEP, JGC, JH, JS, KA, KDP, LMM, LS, MF, MW, NM, PEG, RPJ, SA, SWK, TMM, TMO and VF) found that the documentation for all episodes supported the decision to place the individual in restraint. Less restrictive alternatives attempted were documented in all episodes and orders that included specific behaviors were found in all episodes.</p> <p data-bbox="991 868 1457 933">Current recommendation: Continue to monitor this requirement.</p>	1.	<i>Restraint is used in a documented manner.</i>	98%	2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%	3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	99%
1.	<i>Restraint is used in a documented manner.</i>	98%									
2.	<i>Restraint is used only when the individual posed an imminent danger to self or others.</i>	100%									
3.	<i>Restraint is used after a hierarchy of less-restrictive measures has been considered in a clinically justifiable manner or exhausted.</i>	99%									
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	<p data-bbox="991 982 1591 1015">Current findings on previous recommendations:</p> <p data-bbox="991 1055 1562 1088">Recommendations 1 and 2, December 2009:</p> <ul data-bbox="991 1096 1856 1193" style="list-style-type: none"> • Continue to implement strategies to increase compliance with this requirement. • Continue to monitor this requirement. <p data-bbox="991 1242 1104 1274">Findings:</p> <p data-bbox="991 1282 1894 1380">Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (November 2009-April 2010):</p>									

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

		4.	<i>Seclusion is not used in the absence of, or as an alternative to, active treatment.</i>	95%
		5.	<i>The individual has been in seclusion and the staff did NOT [use seclusion in an abusive manner, keep the individual in seclusion even when the individual was calm, use seclusion in a manner to show a power differential that exists between staff and the individual, or use seclusion as coercion].</i>	100%
		6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	100%
	<p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for items 1 and 2; the compliance rate for item 3 improved from 40%.</p> <p>A review of three episodes of seclusion for two individuals (AH and MSB) found documentation in both WRPs addressing behaviors, objectives and interventions. Documentation in all episodes indicated that the individual was released when calm.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (November 2009-April 2010):</p>	4.	<i>Restraint is not used in the absence of, or as an alternative to, active treatment.</i>	94%
		5.	<i>The individual has been in restraint and the staff did NOT [use restraint in an abusive manner, keep the individual in restraint even when the individual was</i>	97%

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		<table border="1" data-bbox="991 191 1900 527"> <tr> <td data-bbox="991 191 1094 305"></td> <td data-bbox="1094 191 1793 305"><i>calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i></td> <td data-bbox="1793 191 1900 305"></td> </tr> <tr> <td data-bbox="991 305 1094 527">6.</td> <td data-bbox="1094 305 1793 527"><i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i></td> <td data-bbox="1793 305 1900 527">98%</td> </tr> </table> <p data-bbox="991 570 1900 638">Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period for all items.</p> <p data-bbox="991 683 1900 862">A review of 32 episodes of restraint for 25 individuals (ALA, DB, DLG, DLR, FJ, GDM, GH, JEP, JGC, JH, JS, KA, KDP, LMM, LS, MF, MW, NM, PEG, RPJ, SA, SWK, TMM, TMO and VF) found documentation in all WRPs addressing behaviors, objectives and interventions. Documentation in 31 episodes indicated that the individual was released when calm</p> <p data-bbox="991 906 1900 971">Current recommendation: Continue to monitor this requirement.</p>		<i>calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>		6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	98%
	<i>calm, use restraint in a manner to show a power differential that exists between staff and the individual, or use restraint as coercion].</i>							
6.	<i>Staff used and documented the use of information in the Seclusion and Restraint Preference and Family Notification Form (PSH 1185) regarding the individual's preferences in gaining control of behavior as provided by the individual, or there is clinical justification as to why they were not used.</i>	98%						
H.2.c	are not used as part of a behavioral intervention; and	<p data-bbox="991 1015 1900 1047">Current findings on previous recommendation:</p> <p data-bbox="991 1089 1900 1154">Recommendation, December 2009: See F.2.c.iv.</p> <p data-bbox="991 1198 1900 1263">Findings: See F.2.c.iv.</p> <p data-bbox="991 1307 1900 1372">Current recommendations: See F.2.c.iv.</p>						

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<p>H.2.d</p>	<p>are terminated as soon as the individual is no longer an imminent danger to self or others.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to implement strategies to increase compliance with this requirement. • Continue to monitor this requirement. <p>Findings: Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of episodes of seclusion each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 636 1887 711"> <tr> <td data-bbox="991 636 1087 711">7.</td> <td data-bbox="1087 636 1793 711"><i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 636 1887 711">100%</td> </tr> </table> <p>Comparative data indicated improvement in compliance from 89% in the previous review period.</p> <p>See H.2.b for review findings.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of episodes of restraint each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1081 1887 1156"> <tr> <td data-bbox="991 1081 1087 1156">7.</td> <td data-bbox="1087 1081 1793 1156"><i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i></td> <td data-bbox="1793 1081 1887 1156">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>See H.2.b for review findings.</p>	7.	<i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	100%	7.	<i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	95%
7.	<i>Seclusion is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	100%						
7.	<i>Restraint is terminated as soon as the individual is no longer an imminent danger to self or others.</i>	95%						

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		<p>Current recommendation: Continue to monitor this requirement.</p>						
<p>H.3</p>	<p>Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to implement strategies to increase compliance with this requirement. • Continue to monitor this requirement. <p>Findings: Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial seclusion orders each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 748 1887 898"> <tr> <td data-bbox="991 748 1087 898">8.</td> <td data-bbox="1087 748 1793 898"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</i></td> <td data-bbox="1793 748 1887 898">95%</td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of three episodes of seclusion for two individuals (AH and MSB) found that the RN conducted a timely assessment in all episodes and that the individual was timely seen by a psychiatrist in all episodes.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 100% sample of initial restraint orders each month during the review period (November 2009-April 2010):</p> <table border="1" data-bbox="991 1344 1887 1416"> <tr> <td data-bbox="991 1344 1087 1416">8.</td> <td data-bbox="1087 1344 1793 1416"><i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or</i></td> <td data-bbox="1793 1344 1887 1416">93%</td> </tr> </table>	8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</i>	95%	8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or</i>	93%
8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or licensed clinical professional of any individual placed in seclusion within one hour.</i>	95%						
8.	<i>Each State Hospital shall comply with 42 C.F.R., 483.360(f) requiring assessments by a physician or</i>	93%						

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

		<table border="1" data-bbox="991 191 1887 267"> <tr> <td data-bbox="991 191 1087 267"></td> <td data-bbox="1087 191 1793 267"><i>licensed clinical professional of any individual placed in restraint within one hour.</i></td> <td data-bbox="1793 191 1887 267"></td> </tr> </table> <p>Comparative data indicated that PSH has maintained a compliance rate of at least 90% from the previous review period.</p> <p>A review of 32 episodes of restraint for 25 individuals (ALA, DB, DLG, DLR, FJ, GDM, GH, JEP, JGC, JH, JS, KA, KDP, LMM, LS, MF, MW, NM, PEG, RPJ, SA, SWK, TMM, TMO and VF) found that the RN conducted a timely assessment in 30 episodes and that the individual was timely seen by a psychiatrist in 31 episodes.</p> <p>PSH's training rosters verified that annual staff training for TSI (Therapeutic Strategies and Interventions) was at 90% compliance.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue to monitor this requirement.</p>		<i>licensed clinical professional of any individual placed in restraint within one hour.</i>	
	<i>licensed clinical professional of any individual placed in restraint within one hour.</i>				
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Develop and implement a system to ensure accuracy of seclusion and restraint data if the WaRMSS system continues to be inaccurate. • Continue to monitor this requirement. <p>Findings: The data entry for seclusion and restraint episodes went from a decentralized process to a centralized process in January 2010. PSH has one part-time and two full-time staff members who are responsible for inputting the seclusion and restraint data into WaRMSS. Monday</p>			

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		<p>through Friday, the Data Collection Monitoring Coordinator tracks each seclusion and restraint episode and logs it into a spreadsheet. That information is used to perform Risk Management Committee reviews, develop trigger data and perform auditing functions. Accuracy has been 92% to 97%.</p> <p>Since April 2009, PSH continues to use the MedSelect system throughout the facility. This system captures PRN and Stat data by unit, individual, time and user. These data are compared to the HSS reports and CIS databases to ensure accuracy. A review of PRN/Stat medications and seclusion and restraint episodes found no incidents that were not included in the PSH databases.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.5	<p>Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendations 1 and 2, December 2009:</p> <ul style="list-style-type: none"> • Continue to implement strategies to increase compliance with this requirement. • Continue to monitor this requirement. <p>Findings: There have been no incidents of seclusion four or more times in a four-week period during this review period.</p> <p>Using the DMH Seclusion/Restraint Audit, PSH assessed its compliance based on a 93% sample of individuals who were in restraint more than three times in 30 days during the review period (November 2009-April</p>

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

		<p>2010):</p> <table border="1" data-bbox="991 264 1887 937"> <tr> <td data-bbox="991 264 1087 488">9.</td> <td data-bbox="1087 264 1793 488"><i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i></td> <td data-bbox="1793 264 1887 488">93%</td> </tr> <tr> <td data-bbox="991 488 1087 602">9.a</td> <td data-bbox="1087 488 1793 602"><i>The review was held within three business days for any individual who had four or more episodes of restraint within the last 30 days</i></td> <td data-bbox="1793 488 1887 602">78%</td> </tr> <tr> <td data-bbox="991 602 1087 716">9.b</td> <td data-bbox="1087 602 1793 716"><i>The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done</i></td> <td data-bbox="1793 602 1887 716">100%</td> </tr> <tr> <td data-bbox="991 716 1087 937">9.c</td> <td data-bbox="1087 716 1793 937"><i>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</i></td> <td data-bbox="1793 716 1887 937">100%</td> </tr> </table> <p data-bbox="991 979 1887 1047">Comparative data indicated improvement in the compliance rate for the main indicator from 77% in the previous review period.</p> <p data-bbox="991 1089 1902 1232">A review of the records of six individuals who were in restraint more than three times in 30 days during the review period (ALA, LS, MW, PEG, RPJ and SA) found that all WRPs included documentation within three business days.</p> <p data-bbox="991 1274 1142 1343">Compliance: Substantial.</p>	9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	93%	9.a	<i>The review was held within three business days for any individual who had four or more episodes of restraint within the last 30 days</i>	78%	9.b	<i>The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done</i>	100%	9.c	<i>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</i>	100%
9.	<i>Required to review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in restraint more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate</i>	93%												
9.a	<i>The review was held within three business days for any individual who had four or more episodes of restraint within the last 30 days</i>	78%												
9.b	<i>The Present Status in the Case Formulation section of the WRP documented that a review of the incident(s) was done</i>	100%												
9.c	<i>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</i>	100%												

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

		<p>Current recommendation: Continue to monitor this requirement.</p>
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	<p>Compliance: Substantial.</p>
H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendations: See F.1.b.</p>
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendations: See F.1.b.</p>
H.6.c	PRN medications are appropriately time limited.	<p>Current findings on previous recommendation:</p>

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

		<p>Recommendation, December 2009: See F.1.b.</p> <p>Findings: See F.1.b.</p> <p>Current recommendations: See F.1.b.</p>
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: See F.3.a.iii.</p> <p>Findings: See F.3.a.iii.</p> <p>Current recommendations: See F.3.a.iii.</p>
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Same as in D.1.f, F.1.b and H.6.a.</p> <p>Findings: Same as in D.1.f, F.1.b and H.6.a</p> <p>Current recommendations: Same as in D.1.f, F.1.b and H.6.a.</p>
H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation	<p>Current findings on previous recommendation:</p>

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	or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	<p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: See F.3.h.i and H.3.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
H.8	Each State hospital shall:	<p>Compliance: Not applicable.</p>
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to monitor this requirement.</p> <p>Findings: PSH had no use of side rails during the review period.</p> <p>Current recommendation: Continue to monitor this requirement.</p>
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms,	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: See H.8.a.</p>

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

	and strategies to reduce the use of side rails, if appropriate.	Findings: See H.8.a. Current recommendations: See H.8.a.
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Section I: Protection from Harm

I. Protection from Harm		
I	<p>Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.</p>	<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The facility has been successful in providing annual training for staff members, ensuring that non-clinical Mall providers complete the training curriculum and offering individuals an annual review of their rights and the opportunity to sign the rights acknowledgement form. 2. PSH is tracking recommendations from the review of incidents and from the review of deaths through to implementation. 3. The facility acknowledged the errors pointed out in the investigations reviewed and adopted a strategy to immediately rectify the deficient practice through additional in-service training. 4. PSH has adopted a system for ensuring that a completed SIR follows each incident reported. On the units, staff enter the complete first page of the SIR in WaRMSS and in so doing the SIR is assigned a number. Unit staff fax the completed hard-copy SIR to Standards Compliance, where staff match the completed form with the face sheet. 5. The facility's procedure for making decisions about removing staff members named in allegations of A/N/E appears to function well and variations from this procedure are recognized and dealt with. 6. In an improvement from earlier reviews, the facility has addressed with counseling staff members' failure to report allegations of A/N/E in the manner required by policy. 7. To enhance the performance of the Program Review Committees and to reduce the number of referrals to the ETRC, the facility's new Acting Assistant Medical Director will be providing training to all Program Directors. 8. Most of the reviews of the WRPTs' responses to incidents, triggers, high risk status and Risk Management committees' recommendations yielded positive findings. WRPs referenced incidents, triggers, and high risk status, and a focus of treatment was directed at the behavior or condition. With only one exception, recommendations made by the ETRC were implemented, in process, or a rationale was provided for why

Section I: Protection from Harm

		<p>implementation was no longer required.</p> <ol style="list-style-type: none">9. The monthly environmental reviews occurred as planned and were reviewed by the Health and Safety Officer. All units responded to deficiencies noted in Health and Safety inspections with a plan of corrective action.10. The facility continues to make environmental modifications to reduce suicide hazards as resources are available. The refurbishing of the bathrooms continues. The first shipment of new wardrobes is due to arrive at the facility soon. These wardrobes have no hinges and have a slanted top—features specifically designed to improve safety.11. In response to findings that the implementation of the process for accounting for cords and adapters was flawed, the facility immediately corrected the situation and determined that the improved system would be implemented across the facility.
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Section I: Protection from Harm

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Sherer, Hospital Administrator 2. G. Richardson, Standards Compliance Director 3. J. Chencharick, Supervising Special Investigator, Acting 4. J. D'Braustein, Standards Compliance 5. J. Malancharuvil, PhD, Clinical Administrator <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. 14 investigation reports 2. IRC minutes and task tracking form 3. Selected personnel information related to 11 staff members 4. Signed notification of rights forms for 17 individuals 5. Nine Headquarters Briefs 6. Aggression and A/N/E data provided by the facility 7. HPD listing of A/N/E incidents by victim and by named staff member 8. All materials related to the deaths of two individuals
I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	<p>Compliance: Substantial.</p>
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Follow DMH guidelines for addressing staff members' failure to report abuse allegations.</p>

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		<p>Findings: Please see I.1.a.v for two examples of the facility's attention to the failure to report identified in one of the investigations reviewed.</p> <p>Current recommendation: Continue to apply progressive discipline to staff members who fail to report allegations of A/N/E according to DMH policy.</p>
I.1.a.ii	<p>identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: PSH has recently determined that allegations of verbal abuse will be investigated by the Hospital Police. The completed investigation report will be forwarded to the Supervising Special Investigator for review and approval. These investigations will continue to be reviewed by the Incident Review Committee.</p> <p>Other findings: The SIR incident definitions are used in making determinations.</p> <p>Current recommendation: Ensure that verbal abuse investigations are carefully reviewed and any that do not meet standards are redone.</p>
I.1.a.iii	<p>mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice of monitoring the implementation of procedures seeking the approval of the Clinical Director for decisions not to reassign a named staff member.</p>

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	<p>contact with the involved individuals pending the outcome of the facility's investigation;</p>	<p>Findings: Facility policy dictates that the decision to not remove the named staff member must be approved by the Clinical Administrator. The investigation reports reviewed consistently addressed the removal of or decision not to remove the named staff member. For example, PG shouted he was having a heart attack because he had been assaulted by a staff member ten minutes earlier. PG was immediately assessed by the nurse (no abnormal findings) and refused examination by the physician. The investigation report notes that the named staff person was not removed "with the approval of the Clinical Administrator." In contrast, the investigation of the alleged failure of a staff member to protect an individual from an assault by a peer during a Mall group found that the named staff member was not removed. This was identified as a problem because the Clinical Administrator had not been consulted.</p> <p>Current recommendation: Continue current practice or apply DMH guidelines for removing named staff, should they prescribe a different procedure.</p>
<p>I.1.a.iv</p>	<p>adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: As presented in the table below, nine of the 11 staff members whose A/N training records were reviewed had participated in Abuse/Neglect training within the past year.</p>

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		<table border="1" data-bbox="953 228 1822 802"> <thead> <tr> <th rowspan="2">Staff member*</th> <th colspan="4">Date of:</th> </tr> <tr> <th>Hire</th> <th>Background clearance</th> <th>Signing of Mandatory Reporter</th> <th>Most recent A/N training</th> </tr> </thead> <tbody> <tr> <td>_F</td> <td>8/30/96</td> <td>7/16/96</td> <td>8/30/96</td> <td>1/27/09</td> </tr> <tr> <td>_P</td> <td>2/1/99</td> <td>12/17/98</td> <td>2/1/99</td> <td>4/7/10</td> </tr> <tr> <td>_S</td> <td>3/2/99</td> <td>1/15/99</td> <td>3/2/99</td> <td>3/18/10</td> </tr> <tr> <td>_D</td> <td>1/3/00</td> <td>10/27/99</td> <td>1/3/00</td> <td>3/15/10</td> </tr> <tr> <td>_A</td> <td>2/1/00</td> <td>12/23/99</td> <td>2/1/00</td> <td>4/2/09</td> </tr> <tr> <td>_C</td> <td>7/3/00</td> <td>5/19/00</td> <td>7/3/00</td> <td>8/27/09</td> </tr> <tr> <td>_D</td> <td>6/10/04</td> <td>6/23/04</td> <td>9/17/04</td> <td>1/7/10</td> </tr> <tr> <td>_S</td> <td>5/2/06</td> <td>3/18/06</td> <td>5/2/06</td> <td>1/28/10</td> </tr> <tr> <td>_W</td> <td>3/3/08</td> <td>3/11/08</td> <td>11/17/08</td> <td>1/28/10</td> </tr> <tr> <td>_K</td> <td>7/31/08</td> <td>6/24/08</td> <td>7/31/08</td> <td>4/5/10</td> </tr> <tr> <td>_B</td> <td>2/1/10</td> <td>12/15/09</td> <td>2/1/10</td> <td>6/2/10</td> </tr> </tbody> </table> <p data-bbox="953 808 1598 834">*Only last initials are provided to protect confidentiality.</p> <p data-bbox="953 878 1283 946">Current recommendation: Continue current practice.</p>	Staff member*	Date of:				Hire	Background clearance	Signing of Mandatory Reporter	Most recent A/N training	_F	8/30/96	7/16/96	8/30/96	1/27/09	_P	2/1/99	12/17/98	2/1/99	4/7/10	_S	3/2/99	1/15/99	3/2/99	3/18/10	_D	1/3/00	10/27/99	1/3/00	3/15/10	_A	2/1/00	12/23/99	2/1/00	4/2/09	_C	7/3/00	5/19/00	7/3/00	8/27/09	_D	6/10/04	6/23/04	9/17/04	1/7/10	_S	5/2/06	3/18/06	5/2/06	1/28/10	_W	3/3/08	3/11/08	11/17/08	1/28/10	_K	7/31/08	6/24/08	7/31/08	4/5/10	_B	2/1/10	12/15/09	2/1/10	6/2/10
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I.1.a.v	<p data-bbox="354 987 926 1419">notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</p>	<p data-bbox="953 987 1556 1019">Current findings on previous recommendations:</p> <p data-bbox="953 1062 1871 1166">Recommendation 1, December 2009: Follow AD 15.13 regarding corrective and disciplinary action for failure to report.</p> <p data-bbox="953 1208 1913 1419">Findings: The investigation of alleged physical abuse of PG was determined not sustained. The named staff member, however, was found in violation of the duty to report. A letter of counseling was placed in his personnel file for this failure. In another investigation, a staff member was found to have been negligent for failing to complete an incident report. This staff member</p>																																																																

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		<p>was verbally counseled by the supervisor and a letter of instruction was placed in the staff member's personnel file.</p> <p>Recommendation 2, December 2009: Ensure that staff members sign the Mandatory Reporter acknowledgement form and understand the responsibilities associated with it before they begin working in contact with individuals.</p> <p>Findings: As shown in the table in I.1.a.iv, one staff member was considerably late in attending annual training, having last attended training in January 2009.</p> <p>Current recommendation: Continue current practice including monitoring for training attendance at the time of annual evaluation to ensure compliance with the facility's expectation for annual training.</p>								
I.1.a.vi	<p>mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: As shown below, only one of the individuals sampled was seriously overdue in having been afforded the opportunity to review and sign the rights statement. Staff could not locate the signed statement in the record of a second individual.</p> <table border="1" data-bbox="961 1227 1415 1417"> <thead> <tr> <th>Individual</th> <th>Date of most recent signing</th> </tr> </thead> <tbody> <tr> <td>EH</td> <td>Cannot locate</td> </tr> <tr> <td>AD</td> <td>11/22/07</td> </tr> <tr> <td>RG</td> <td>5/5/09</td> </tr> </tbody> </table>	Individual	Date of most recent signing	EH	Cannot locate	AD	11/22/07	RG	5/5/09
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I.1.a. vii	posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;	<p>Current recommendation: Continue current practice, including internal monitoring.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: All units visited had a poster in a common area stating the rights of individuals and providing the name and number of the Patients Rights Advocate. In addition, the name and telephone number of the Clinical Administrator is posted and individuals are free to call his office with their concerns.</p> <p>Current recommendation: Continue current practice.</p>																												

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<p>I.1.a. viii</p>	<p>procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: DMH should investigate the circumstances described [in this cell in the previous report], determine the accuracy and provide guidance to investigators on how to proceed if it appears that an individual has committed a crime.</p> <p>Findings: Three investigations reviewed demonstrate the facility's awareness of the responsibility to report appropriate cases to law enforcement. The investigation of the alleged sexual abuse of CH (6/20/09) determined the allegation to be unsubstantiated. The investigation concluded that the case did not meet the criteria for filing with the San Bernardino District Attorney.</p> <p>The incident of aggression that resulted in a portion of KD's ear being bitten off by a peer (12/3/09) was forwarded to the District Attorney and accepted. The peer was charged with battery with serious injury and mayhem—unlawfully and maliciously depriving a human being of a body part. In the investigation of the serious injury to a staff member on 3/24/10, the individual (TM) was arrested and sent to West Valley Detention Center. When she returned to PSH, she was placed on a different unit, and staff were alerted to maintain vigilance.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.a.ix</p>	<p>mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands,</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p>

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	<p>discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.</p>	<p>Findings: The issue of retaliation or fear of retaliation for the reporting of incidents did not arise in the investigations reviewed.</p> <p>Current recommendation: Maintain vigilance in questioning individuals about retaliation for reporting incidents, particularly when an individual withdraws an allegation.</p>
<p>I.1.b</p>	<p>Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:</p>	<p>Compliance: Partial; additional work is needed to complete investigations within the timeframe set by the EP, conduct timely interviews and match determinations with the SIR definition.</p>
<p>I.1.b.i</p>	<p>require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to track all MIRC recommendations through to completion.</p> <p>Findings: Two individuals died within the review period: TH died in the San Diego Central Jail on 1/17/10, having been transferred there 10 days earlier and MB completed suicide by hanging on the morning of 1/4/10 at PSH.</p> <ul style="list-style-type: none"> • The initial MIRC review for TH was conducted on 2/2/10, followed by the Independent External Review on 2/21/10. The final MIRC (4/13/10) traced the recommendations from these reviews and determined that in-service training for medical staff on the use of the High Concern Medical Refusal Protocol had been completed and will be ongoing. All future MIRC Medical Death Summaries will address all issue areas required by SO 205 and will be signed and dated. Additional death review recommendations were also addressed. • The initial MIRC review of the death of MB occurred on 1/13/10 and a

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		<p>psychological autopsy was conducted on 1/18/10. The Independent External Review followed on 2/7/10. The final MIRC review occurred on 4/13/10. The MIRC reviews, the External Review and the OSI investigation raised questions regarding where/how did MB obtain the electrical cord and how did he cut it. Questions related to how MB's refusal of medication beginning in November 2009 was handled and the need for a physician's note when significant changes in medication are made also surfaced. The final MIRC review documented that Medical Staff Bylaws currently address the requirement for a physician's note when medications are changed, further investigation has not shed light on how MB obtained and trimmed the electrical cord, and the "new involuntary medication panel and process" will address decisions not to continue involuntary medication after the order has expired.</p> <p>Current recommendation: Continue to track all MIRC recommendations through to completion.</p>
I.1.b.ii	<p>ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Special Investigators and hospital police investigate incidents.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b.iii	<p>investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p>

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		<p>Findings: In several investigations reviewed, evidence was collected and secured. Specifically, in the investigation of the assault of RF by peers, the HPD officer collected blood-stained slippers and pajamas and took photos of the victim and the scene. Photos of the room in which the activity was reported to have occurred were taken and secured in the investigation of the allegation of sexual abuse of TM.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b.iv	<p>investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Ensure that all investigators use the preponderance of evidence standard in making determination.</p> <p>Findings: The facility reports that investigators have been reminded that preponderance is the evidence level to be used in making determinations. Many investigation reports reviewed specifically noted that this standard was being applied in making determinations. See also I.1.b.iv.3(viii).</p> <p>Recommendation 2, December 2009: Request that preliminary investigators be mindful of the need to interview the named staff member as expeditiously as possible.</p> <p>Findings: This issue did not arise during this review.</p> <p>Other findings: The features of investigations that did not meet practice standards are identified in the cells below.</p>

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		<p>Current recommendation: Maintain a critical review of the accuracy and completeness of investigations as a protection to both individuals and staff members.</p>																																																
<p>I.1.b. iv.1</p>	<p>investigations commence within 24 hours or sooner, if necessary, of the incident being reported</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue efforts to pass incidents on to OSI in as timely manner as possible so that the investigations can begin.</p> <p>Findings: As shown in the table below, all but one of the allegations of A/N/E reviewed were received in the OSI within three days of being reported.</p> <table border="1" data-bbox="955 748 1896 1422"> <thead> <tr> <th>Allegation Type</th> <th>Date reported</th> <th>Date to OSI</th> <th>Date closed</th> </tr> </thead> <tbody> <tr> <td>Sexual Abuse</td> <td>11/23/09</td> <td>11/24/09</td> <td>5/17/10</td> </tr> <tr> <td>Abuse and Neglect</td> <td>3/16/10</td> <td>3/16/10</td> <td>4/14/10</td> </tr> <tr> <td>Rape</td> <td>DOI: 3/21/10</td> <td>3/24/10</td> <td>4/12/10</td> </tr> <tr> <td>Assault</td> <td>DOI: 1/1/10</td> <td>HP investigation</td> <td></td> </tr> <tr> <td>Physical and Verbal Abuse</td> <td>DOI: 12/15/09</td> <td>12/16/09</td> <td>1/21/10</td> </tr> <tr> <td>Neglect</td> <td>DOI: 1/5/10</td> <td>1/7/10</td> <td>4/6/10</td> </tr> <tr> <td>Failure to Report/Protect</td> <td>12/14/09</td> <td>1/5/10</td> <td>2/23/10</td> </tr> <tr> <td>Rape/Sexual Abuse</td> <td>11/22/09</td> <td>11/25/09</td> <td>12/19/09</td> </tr> <tr> <td>Physical Abuse</td> <td>DOI: 12/18/09</td> <td>12/18/09</td> <td>3/8/10</td> </tr> <tr> <td>Physical Abuse and Medical Neglect</td> <td>DOI: 12/15/09</td> <td>12/18/09</td> <td>3/15/10</td> </tr> <tr> <td>Verbal buse</td> <td>4/5/10</td> <td>4/5/10</td> <td>4/26/10</td> </tr> </tbody> </table>	Allegation Type	Date reported	Date to OSI	Date closed	Sexual Abuse	11/23/09	11/24/09	5/17/10	Abuse and Neglect	3/16/10	3/16/10	4/14/10	Rape	DOI: 3/21/10	3/24/10	4/12/10	Assault	DOI: 1/1/10	HP investigation		Physical and Verbal Abuse	DOI: 12/15/09	12/16/09	1/21/10	Neglect	DOI: 1/5/10	1/7/10	4/6/10	Failure to Report/Protect	12/14/09	1/5/10	2/23/10	Rape/Sexual Abuse	11/22/09	11/25/09	12/19/09	Physical Abuse	DOI: 12/18/09	12/18/09	3/8/10	Physical Abuse and Medical Neglect	DOI: 12/15/09	12/18/09	3/15/10	Verbal buse	4/5/10	4/5/10	4/26/10
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I.1.b. iv.2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue efforts to complete investigations within the timeframe required by the Enhancement Plan.</p> <p>Findings: As demonstrated in the table above, nine of the 13 relevant investigations reviewed were completed within the 30 business day timeframe specified in the EP.</p> <p>A listing of open investigations provided during the CM visit indicated that 35 investigations have been open for more than 30 business days, some dating back to November 2009.</p> <p>Other findings: See also I.1.a.ii for one of the facility's measures to decrease the OSI workload and increase timeliness.</p> <p>Current recommendation: Take steps to complete investigations in a timely manner.</p>												

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<p>I.1.b. iv.3</p>	<p>each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Determine the factors that impede timeliness in implementing disciplinary action and take action where possible.</p> <p>Findings: The facility has tracked the timeliness of disciplinary action. More recent examples show greater success:</p> <ul style="list-style-type: none"> • In the sustained case of verbal abuse closed on 1/21/10, the named staff member received a Letter of Warning on 5/10/10. • The named staff person was terminated effective June 9, 2010 in a sustained case of neglect closed on 4/6/10. • The named staff member was found to have failed to report an allegation of abuse in the investigation closed on 3/15/10. This staff member received a Letter of Counseling on 5/13/10. <p>Other findings: The investigation of the allegation of psychological abuse of unknown individuals resulted in a faulty and stigmatizing sustained determination. The named staff member was suspected of providing contraband to individuals. The investigation found no evidence that he was engaged in this behavior. However, during an interview, the named staff member acknowledged that once a while ago he had brought in burritos for his IT team to thank them for their assistance. With no rationale and based on this violation of policy, the allegation of psychological abuse was sustained. This error could have been avoided had the investigator linked the finding of fact (bringing in food) with the definition of psychological abuse; it would have been clear that there was no way to construe that action as abuse. The Chair of the IRC acknowledged the error and agreed to ensure that the determination is overturned and the employee's record corrected if necessary. In addition, the Chair of the IRC will be providing an in-service</p>
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		<p>training to the OSI investigators on the need for strict adherence to the SIR definitions in making determinations.</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Match the findings of fact to the relevant portion of the SIR incident definition. 2. As planned, provide training to the OSI investigators on the use of the SIR definitions in making determinations.
I.1.b. iv.3(i)	each allegation of wrongdoing investigated;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Each of the investigation reports reviewed described the circumstances of the allegation(s) under investigation.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3(ii)	the name(s) of all witnesses;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Most of the investigations reviewed identified the witnesses and provided a summary of the interview of that person. During the investigation of the assault of RF, the hospital police investigation did not document an effort to determine where staff members were when RF was assaulted by three peers in the day room (or slammed his head into the pool table).</p>

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		<p>Current recommendation: Document efforts to identify all possible witnesses among both individuals and staff members.</p>
I.1.b. iv.3(iii)	the name(s) of all alleged victims and perpetrators;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: All investigation reports reviewed clearly identified the alleged victims and alleged perpetrators.</p> <p>Current recommendation: Continue current practice.</p>
I.1.b. iv.3(iv)	the names of all persons interviewed during the investigation;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: In the investigation of the allegation of physical abuse and medical neglect (12/15/09), the investigator made a decision not to interview the alleged victim, but did not provide a rationale for this decision. In contrast, during the investigation of the 1/5/10 allegation of neglect, the named staff member was not interviewed. The investigator explained that the staff member was placed off duty by his physician and was not available for interview.</p> <p>The investigation of the allegation of the sexual abuse of TM was seriously marred by the failure to conduct interviews in a timely manner as illustrated:</p>

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		<p>Date incident reported: 11/23/09 Interview of TM: 11/24-25/09 Interview of named staff member: 12/10/09 Interview of other unit staff: 3/19/10 Interview of named staff member's supervisor: 5/14/10 Interview of staff with information about unit searches: 5/14, 5/17/10</p> <p>Current recommendations:</p> <ol style="list-style-type: none"> 1. Provide a rationale when an investigator makes a decision to depart from standard investigation practice. 2. Conduct interviews as proximate to the event as possible.
<p>I.1.b. iv.3(v)</p>	<p>a summary of each interview;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: All of the investigation reports reviewed contained a summary of each interview conducted.</p> <p>Other findings: In the investigation of the allegation of physical assault, the investigator did not conduct complete interviews. Specifically, RF initially alleged he was assaulted by three peers in the dayroom. He suffered head injury and was taken to a local hospital. Several days later he said he inflicted the injuries on himself by hitting his head on the corner of the pool table in the dayroom. The investigation failed to document any attempt to find out where staff were when RF was either assaulted or harming himself in the dayroom. Furthermore, in the interview with one of the individuals whom RF alleged assaulted him, the individual explained he was watching TV in the dayroom "when the incident occurred," did not want to be involved and</p>

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		<p>"walked out while the incident was in progress." The investigator apparently did not question the individual sufficiently to learn the nature of the incident the individual was trying to avoid being involved in.</p> <p>Current recommendation: When open-ended questions do not provide sufficient information, the investigator should ask specific questions that will solicit the required information or will clarify that the interviewee cannot/will not provide the information.</p>
<p>I.1.b. iv.3(vi)</p>	<p>a list of all documents reviewed during the investigation;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: All of the investigation reports reviewed included a listing of documents reviewed. This listing is an item in the report format.</p> <p>Current recommendation: Continue current practice.</p>
<p>I.1.b. iv.3 (vii)</p>	<p>all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: DMH needs to provide guidance to the facilities on its expectations for how they should comply with this section of the EP, since at this time there is no consistency among the facilities.</p> <p>Findings: Development of this guidance is still in process.</p>

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		<p>Other findings: In nine of the relevant investigation reports reviewed, specific mention is made of the number of previous abuse allegations made by the individual. None of the investigation reports included a count of the number of allegations made against the staff member. On a periodic basis, a report is produced for the IRC listing staff members who have been involved in A/N/E incidents. Under each staff member's name is a listing of the incidents (with date and type) in which the staff member has been involved and his/her role. Please see I.1.d.ii for more discussion of this listing.</p> <p>Current recommendation: Ensure that the IRC is able to review staff members' incident histories on a frequent periodic basis, since investigations do not include this information.</p>
<p>I.1.b. iv.3 (viii)</p>	<p>the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Use the preponderance of evidence standard in making determinations at the close of investigations.</p> <p>Findings: See the description of the investigation of the allegation of verbal and physical abuse in the cell below. The investigator's conclusion regarding physical abuse raises questions about the application of the preponderance of evidence standard. Furthermore, had the interviews not been conducted nearly a month after the incident, the individual might have been able to remember the incident and more precise questioning of the reporting staff member would have been possible and might have resulted in specific information about her location when she observed the incident.</p> <p>Other findings: The investigation of the allegation of psychological abuse (4/1-4/4/10) determined that the named staff member brought food from outside for</p>

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		<p>several individuals in his group as a means of thanking them for their help. This violates facility policy. The allegation of psychological abuse was sustained for this policy violation. The actions of the staff member did not meet the SIR definition of psychological abuse, however. This was discussed with the Supervising Special Investigator and Hospital Administrator, who agreed to change the determination, so that the staff member would not carry the stigma of having engaged in abusive behavior.</p> <p>Current recommendation: Link the determination with the relevant portion of the incident definition.</p>
<p>I.1.b. iv.3(ix)</p>	<p>the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice of close review of investigations by the Incident Review Committee.</p> <p>Findings: Members of the IRC continue to receive a copy of the complete investigation report and a copy of the hospital police report prior to the review of the investigation at the meeting.</p> <p>Other findings: In the investigation of the allegations of physical and verbal abuse (12/5/09), a staff witness reported that the named staff member pushed PL in the shoulder/chest, causing PL to take several steps backward into the wall when PL grabbed for the cookie that the 1:1 staff member was eating. The named staff member said she grabbed PL's sweatshirt to move her aside. PL had no recollection of the specific incident. The investigator did not acknowledge the conflicting evidence and did not take additional actions to reconcile the two versions of the event. The investigator sustained the allegation of verbal abuse, as the named staff member acknowledged using profanity—"Don't touch my ___ing food." The allegation of physical abuse</p>

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		<p>was not substantiated. Despite not having made a finding about what actions the staff member engaged in, the investigator concluded that it was "clear" that the staff member's actions were necessary and not inappropriate.</p> <p>Current recommendation: Acknowledge conflicting evidence and take additional investigatory steps to reconcile the disparities whenever possible.</p>
<p>I.1.b. iv.4</p>	<p>staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: All of the investigations reviewed were approved by the Supervising Special Investigator as indicated by his signature. The deficiencies in the investigations documented in this report were not identified during the supervision process.</p> <p>Current recommendation: Exercise vigilance in reviewing and approving investigation reports.</p>
<p>I.1.c</p>	<p>Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.</p>	<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Determine the factors that impede timeliness in implementing disciplinary action and take action where possible.</p> <p>Findings: Please see I.1.b.iv.3.</p>

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		<p>Recommendation 2, December 2009: Add disciplinary action to the IRC task tracking sheet in a manner that protects staff member's privacy but which ensures review of required actions to ensure timeliness.</p> <p>Findings: The IRC Investigation Tracking form provides the date, type, outcome and any follow-up action that needs to occur. This can be disciplinary action, referral to the ETRC, and implementation of programmatic recommendations. Each of the follow-up actions is tracked through to completion.</p> <p>Other findings: The IRC identified two policy issues that required follow-up—whether restrooms should be locked during Mall time and review of AD 15.08 as it relates to 1:1 supervision while transporting individuals. The Hospital Administrator said that Program Directors are discussing the question of locking the restrooms. This discussion follows discussion of the topic by the Individuals Council. AD 15.08 was revised and made effective 12/22/09. It clarifies procedures for enhanced supervision of individuals transported in a van.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	<p>Compliance: Substantial.</p>

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I.1.d.i	type of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide analysis of the violence data presented to the Quality Council.</p> <p>Findings:</p> <table border="1" data-bbox="955 451 1900 930"> <thead> <tr> <th rowspan="2">Abuse type</th> <th rowspan="2">May 09- Oct 09</th> <th rowspan="2">Nov 09- Apr 10</th> <th rowspan="2">Nov 09-Apr 10 investigations completed</th> <th colspan="2">Nov 09-Apr 10 determinations</th> </tr> <tr> <th>Sustained</th> <th>Not sustained</th> </tr> </thead> <tbody> <tr> <td>Physical</td> <td>58</td> <td>41</td> <td>11</td> <td>1</td> <td>10</td> </tr> <tr> <td>Verbal</td> <td>21</td> <td>30</td> <td>9</td> <td>1</td> <td>8</td> </tr> <tr> <td>Psychological</td> <td>14</td> <td>15</td> <td>6</td> <td>2</td> <td>4</td> </tr> <tr> <td>Sexual</td> <td>15</td> <td>5*</td> <td>3**</td> <td>0</td> <td>2</td> </tr> <tr> <td>Neglect</td> <td>6</td> <td>11</td> <td>6</td> <td>5</td> <td>1</td> </tr> <tr> <td>Exploitation</td> <td>0</td> <td>1</td> <td>1</td> <td>1</td> <td>0</td> </tr> <tr> <td>Other</td> <td>2</td> <td>Not provided</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Total</td> <td>116</td> <td>103</td> <td>36</td> <td></td> <td></td> </tr> </tbody> </table> <p>* This number is derived from the Hospital Police listing of incidents by victim for the period 1/1/09-2/28/10. Thus, this data does not capture any sexual abuse allegations for March and April 2010. ** One sexual abuse cases was reported as "for information."</p> <p>Current recommendation: Continue current practice including monitoring of trends.</p>	Abuse type	May 09- Oct 09	Nov 09- Apr 10	Nov 09-Apr 10 investigations completed	Nov 09-Apr 10 determinations		Sustained	Not sustained	Physical	58	41	11	1	10	Verbal	21	30	9	1	8	Psychological	14	15	6	2	4	Sexual	15	5*	3**	0	2	Neglect	6	11	6	5	1	Exploitation	0	1	1	1	0	Other	2	Not provided				Total	116	103	36		
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Total	116	103	36																																																							
I.1.d.ii	staff involved and staff present;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide an analysis of the data regarding staff involvement in incidents and document discussion of this material.</p>																																																								

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		<p>Findings: PSH provided the April 13 IRC meeting attendees with a report of staff members named in investigations of A/N/E during the 14-month period January 2009 through February 2010. In addition, the report contained a listing of staff members named in three or more of these investigations. The staff member was unknown in 15 investigations, one staff was named in four investigations, and four staff members were named in three.</p> <p>Current recommendation: Ensure that the IRC is able to review staff members' incident histories on a quarterly basis, since investigations do not address the incident history of staff members.</p>
I.1.d.iii	individuals directly and indirectly involved;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: The facility provided a report on individuals involved as victims in investigations of A/N/E during the period January 2009 through February 2010. The report was presented at the April 13, 2010 IRC meeting. The report contained a separate listing of individuals who had been involved as victim in three or more of these investigations. One individual was involved in 11 incidents, one individual was involved in seven, three were involved in four, and 16 individuals were involved in three incidents. When individuals are involved in incidents that reach trigger limits, the individual is reviewed by a risk management committee.</p> <p>Current recommendation: Continue current practice.</p>

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I.1.d.iv	location of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Expand the location data to include other types of incident, particularly those involving aggression toward self and others.</p> <p>Findings: The facility provided data on the location of two types of incidents during the review period. As shown below, the number of aggressive incidents to others far outnumbers the allegations of A/N/E.</p> <table border="1" data-bbox="955 597 1906 1328"> <thead> <tr> <th colspan="4">A/N/E Incidents</th> <th colspan="4">Physical Aggressive Acts to Others</th> </tr> <tr> <th>Unit 4</th> <th>0</th> <th>Unit 1</th> <th>1</th> <th>Unit 4</th> <th>13</th> <th>Unit 1</th> <th>77</th> </tr> </thead> <tbody> <tr><td>5</td><td>2</td><td>2</td><td>2</td><td>5</td><td>15</td><td>2</td><td>51</td></tr> <tr><td>6</td><td>1</td><td>9</td><td>2</td><td>6</td><td>10</td><td>9</td><td>52</td></tr> <tr><td>11</td><td>4</td><td>10</td><td>0</td><td>11</td><td>15</td><td>10</td><td>3</td></tr> <tr><td>74</td><td>2</td><td>12</td><td>4</td><td>74</td><td>5</td><td>12</td><td>43</td></tr> <tr><td>30</td><td>4</td><td>70</td><td>5</td><td>30</td><td>9</td><td>70</td><td>45</td></tr> <tr><td>31</td><td>0</td><td>71</td><td>4</td><td>31</td><td>16</td><td>71</td><td>52</td></tr> <tr><td>32</td><td>10</td><td>75</td><td>7</td><td>32</td><td>49</td><td>75</td><td>38</td></tr> <tr><td>33</td><td>5</td><td>72</td><td>3</td><td>33</td><td>47</td><td>72</td><td>48</td></tr> <tr><td>22</td><td>2</td><td>73</td><td>1</td><td>22</td><td>33</td><td>73</td><td>20</td></tr> <tr><td>23</td><td>5</td><td>76</td><td>4</td><td>23</td><td>3</td><td>76</td><td>34</td></tr> <tr><td>26</td><td>2</td><td>77</td><td>0</td><td>26</td><td>21</td><td>77</td><td>26</td></tr> <tr><td>27</td><td>3</td><td>20</td><td>3</td><td>27</td><td>27</td><td>20</td><td>17</td></tr> <tr><td></td><td></td><td>21</td><td>1</td><td>34</td><td>25</td><td>21</td><td>13</td></tr> <tr><td></td><td></td><td>24</td><td>4</td><td>35</td><td>3</td><td>24</td><td>15</td></tr> <tr><td></td><td></td><td>25</td><td>3</td><td>36</td><td>9</td><td>25</td><td>27</td></tr> <tr><td></td><td></td><td></td><td></td><td>37</td><td>25</td><td></td><td></td></tr> <tr> <td colspan="2">Total =84</td> <td colspan="2">Mean =3</td> <td colspan="2">Total = 886</td> <td colspan="2">Mean = 27</td> </tr> </tbody> </table> <p>During the review period, 173 incidents of physical aggression to others</p>	A/N/E Incidents				Physical Aggressive Acts to Others				Unit 4	0	Unit 1	1	Unit 4	13	Unit 1	77	5	2	2	2	5	15	2	51	6	1	9	2	6	10	9	52	11	4	10	0	11	15	10	3	74	2	12	4	74	5	12	43	30	4	70	5	30	9	70	45	31	0	71	4	31	16	71	52	32	10	75	7	32	49	75	38	33	5	72	3	33	47	72	48	22	2	73	1	22	33	73	20	23	5	76	4	23	3	76	34	26	2	77	0	26	21	77	26	27	3	20	3	27	27	20	17			21	1	34	25	21	13			24	4	35	3	24	15			25	3	36	9	25	27					37	25			Total =84		Mean =3		Total = 886		Mean = 27	
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Total =84		Mean =3		Total = 886		Mean = 27																																																																																																																																																				

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		<p>were reported as having occurred during Mall hours and 69 during transition.</p> <p>Current recommendation: Continue to provide incident location data to the IRC and in other appropriate forums.</p>																								
I.1.d.v	date and time of incident;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Expand this data to include other incident types.</p> <p>Findings: In response to this recommendation, the facility provided data on aggressive acts to others in addition to A/N/E data by month as shown below:</p> <table border="1" data-bbox="955 784 1276 1016"> <tr><td>November</td><td>140</td></tr> <tr><td>December</td><td>144</td></tr> <tr><td>January</td><td>185</td></tr> <tr><td>February</td><td>160</td></tr> <tr><td>March</td><td>157</td></tr> <tr><td>April</td><td>179</td></tr> </table> <p>PSH data shows fewer incidents of physical aggression toward others occurred on Saturdays during the review period:</p> <table border="1" data-bbox="955 1166 1276 1391"> <tr><td>Sunday</td><td>122</td></tr> <tr><td>Monday</td><td>150</td></tr> <tr><td>Tuesday</td><td>149</td></tr> <tr><td>Wednesday</td><td>134</td></tr> <tr><td>Thursday</td><td>157</td></tr> <tr><td>Friday</td><td>142</td></tr> </table>	November	140	December	144	January	185	February	160	March	157	April	179	Sunday	122	Monday	150	Tuesday	149	Wednesday	134	Thursday	157	Friday	142
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		<table border="1" data-bbox="955 190 1276 228"> <tr> <td>Saturday</td> <td>111</td> </tr> </table> <p>Other findings: During the review period, more allegations of A/N/E were reported on Monday (20) than any other day, according to facility data:</p> <table border="1" data-bbox="955 415 1276 683"> <tr> <td>Sunday</td> <td>12</td> </tr> <tr> <td>Monday</td> <td>20</td> </tr> <tr> <td>Tuesday</td> <td>18</td> </tr> <tr> <td>Wednesday</td> <td>13</td> </tr> <tr> <td>Thursday</td> <td>17</td> </tr> <tr> <td>Friday</td> <td>15</td> </tr> <tr> <td>Saturday</td> <td>15</td> </tr> </table> <p>January and February 2010 showed the least number of reports of A/N/E in the 12-month period May 2009-April 2010 with nine and seven reports respectively. The mean for the time period was 20 allegations per month.</p> <p>The April Quality Council minutes note the increase in aggression between 8:00-8:30 AM and asked the individuals present for suggestions about why this might be. The individuals cited irritability upon awakening, change of shift "busy-ness" and medication distribution. These latter two leave fewer staff to care for the needs of specific individuals.</p> <p>Current recommendation: Continue current practice including the review of the data in appropriate forums such as the IRC and the Quality Council.</p>	Saturday	111	Sunday	12	Monday	20	Tuesday	18	Wednesday	13	Thursday	17	Friday	15	Saturday	15
Saturday	111																	
Sunday	12																	
Monday	20																	
Tuesday	18																	
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I.1.d.vi	cause(s) of incident; and	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue working to complete HQ briefs as required by the Incident Management Special Order.</p>																

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		<p>Findings: The Headquarters Briefs reviewed covered a variety of subjects and levels of review. Specifically:</p> <ul style="list-style-type: none"> • Two briefs related to expected deaths and noted that no MIRC review was required because the individuals had been in an outside facility for a long period of time. • Two briefs related to incidents that occurred in December 2009 (neglect allegation dated 12/3/09 and medical intervention for fractured ribs sustained during a restraint procedure) had not yet been finalized. • The HQ brief regarding the attack on a staff member on 3/24/10 suggested that a stressor that may have contributed to the incident was "the unit being locked down throughout the day due to ongoing unit shakedowns in the West Compound." • The briefs for two incidents (abuse allegations reported on 1/11/09 and an allegation of abuse going back many years reported on 1/6/10) stated that the psychologist would provide 1:1 counseling for both alleged victims. • Although the HQ brief for the allegation of exploitation in which one individual asked for sexual favors from a peer in exchange for contraband is designated as final, there is no determination as to whether the allegation was deemed credible. • The HQ brief related to the incident on 5/16/10 stated that the officers "utilized the OC spray [pepper spray] appropriately." <p>Current recommendation: Monitor HQ briefs for completeness and timeliness.</p>
I.1.d. vii	outcome of investigation.	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p>

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		<p>Findings: The facility provided the information in the table in I.1.d.i regarding the determinations made in A/N/E investigations during the review period.</p> <p>Current recommendation: Continue current practice, including presenting this data to the IRC and at other appropriate forums.</p>
I.1.e	<p>Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff person or volunteer may pose a risk of harm to such individuals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Please see the table in I.1.a.iv, which shows that two of the staff members sampled cleared the background check shortly after being hired. The remainder of the staff members sampled cleared on or before their date of hire. See also I.1.a.iii for discussion of the facility's attention to removing staff members named in A/N/E allegations.</p> <p>Other findings: The facility reported that all staff members who were hired during the review period had completed background and fingerprint checks.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>

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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:	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. C. Brown, Standards Compliance, Risk Manager 2. G. Christison, MD, Acting Medical Director 3. G. Richardson, Standards Compliance Director 4. J. D'Braunstein, Standards Compliance 5. R. DePalmer, Standards Compliance <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Information regarding individuals transferred to external hospitals during the period November 2009-March 2010 2. Monthly Key Indicator Report 3. WRPs of individuals who reached triggers 4. WRPs of individuals on High Risk lists 5. Assault Reduction Taskforce minutes for April and May 2010 6. Implementation of selected ETRC recommendations 7. Quality Council minutes for November 2009-April 2010 <p><u>Observed:</u> Facility Review Committee</p>
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	<p>Compliance: Substantial.</p>
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Produce timely data with analysis. Document discussion of the data in the Quality Council and other appropriate forums.</p>

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		<p>Findings: The data in the table below was shared with the Quality Council.</p> <table border="1" data-bbox="955 341 1843 755"> <thead> <tr> <th></th> <th>May 2009 - October 2009</th> <th>November 2009 - April 2010</th> </tr> </thead> <tbody> <tr> <td>Peer-to-peer aggression resulting in major injury</td> <td>25</td> <td>26</td> </tr> <tr> <td>Aggression to staff resulting in major injury</td> <td>91</td> <td>126</td> </tr> <tr> <td>Individuals with two or more aggressive acts in 7 days</td> <td>117</td> <td>128</td> </tr> <tr> <td>Individuals with four or more aggressive acts in 30 days</td> <td>34</td> <td>46</td> </tr> <tr> <td>Homicide threats</td> <td>53</td> <td>52</td> </tr> </tbody> </table> <p>Review of facility data on external hospital visits for the period November 2009-March 2010 reveals that 22 visits (mostly ER visits) were related to SIB or injuries from peer aggression as shown below.</p> <table border="1" data-bbox="955 941 1822 1395"> <thead> <tr> <th>Individual</th> <th>Date</th> <th>Issue</th> </tr> </thead> <tbody> <tr> <td>KD</td> <td>12/5/09</td> <td>In fight with peer; portion of right ear bitten off</td> </tr> <tr> <td>AA</td> <td>12/5/09</td> <td>Sutures for head trauma</td> </tr> <tr> <td>AT</td> <td>12/7/09</td> <td>Removal of foreign body from ear</td> </tr> <tr> <td>SA*</td> <td>12/8/09</td> <td>Suspected foreign body ingestion</td> </tr> <tr> <td>CG</td> <td>12/9/09</td> <td>Head trauma</td> </tr> <tr> <td>DM</td> <td>12/11/09</td> <td>Facial laceration and head trauma, post assault</td> </tr> <tr> <td>RD</td> <td>12/12/09</td> <td>Head trauma, post assault</td> </tr> <tr> <td>YB</td> <td>12/14/09</td> <td>Alcohol intoxication</td> </tr> <tr> <td>RF</td> <td>1/1/10</td> <td>Multiple scalp sutures post assault by</td> </tr> </tbody> </table>		May 2009 - October 2009	November 2009 - April 2010	Peer-to-peer aggression resulting in major injury	25	26	Aggression to staff resulting in major injury	91	126	Individuals with two or more aggressive acts in 7 days	117	128	Individuals with four or more aggressive acts in 30 days	34	46	Homicide threats	53	52	Individual	Date	Issue	KD	12/5/09	In fight with peer; portion of right ear bitten off	AA	12/5/09	Sutures for head trauma	AT	12/7/09	Removal of foreign body from ear	SA*	12/8/09	Suspected foreign body ingestion	CG	12/9/09	Head trauma	DM	12/11/09	Facial laceration and head trauma, post assault	RD	12/12/09	Head trauma, post assault	YB	12/14/09	Alcohol intoxication	RF	1/1/10	Multiple scalp sutures post assault by
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I.2.a.ii	<p>establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: The ETRC should document a rationale for each of its recommendations.</p> <p>Findings: The ETRC minutes do not provide a rationale for each recommendation, but the intent and rationale for recommendations made at the FRC attended were clearly discussed. This is reported to be the same at the ETRC.</p>																																										

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		<p>Other findings: A review of individuals whose aggression had resulted in a major injury to a peer yielded the finding that in each instance, the WRPT had responded as follows:</p> <table border="1" data-bbox="953 375 1885 862"> <thead> <tr> <th>Individual</th> <th>Trigger Date</th> <th>WRP Response</th> </tr> </thead> <tbody> <tr> <td>LS</td> <td>4/1/10</td> <td>Incident identified in Present Status. Focus 3 addressed aggression. Interventions included med change, enrolled in SAFE, chronicle mood changes.</td> </tr> <tr> <td>TF</td> <td>4/1/10</td> <td>Incident identified in Present Status. Focus 3 addresses aggression. Interventions include use of an anger meter and Enhancing Self Control mall group.</td> </tr> <tr> <td>JF</td> <td>4/1/10</td> <td>Incident identified in Present Status. Focus 3 addresses failure to control anger. Staff will assist JF in using coping skills in problem situations.</td> </tr> </tbody> </table> <p>Similar findings resulted from a review of the WRPs of individual who had four or more aggressive acts to self in 30 consecutive days.</p> <table border="1" data-bbox="953 1010 1885 1385"> <tbody> <tr> <td>NM</td> <td>4/10/10</td> <td>The trigger was noted under Triggers. Focus 3 addressed aggression to self. Interventions include a PBS consult and enrollment in RISE and SAFE.</td> </tr> <tr> <td>RK</td> <td>4/1/10</td> <td>Trigger noted. Focus 3 addresses suicidal behavior. Interventions include a PBS consult and referral to SAFE.</td> </tr> <tr> <td>CH</td> <td>4/28/10</td> <td>Trigger not noted. Focus 3 addresses SIB and parasuicidal behavior. Attending SAFE and will be completing a scrapbook.</td> </tr> </tbody> </table>	Individual	Trigger Date	WRP Response	LS	4/1/10	Incident identified in Present Status. Focus 3 addressed aggression. Interventions included med change, enrolled in SAFE, chronicle mood changes.	TF	4/1/10	Incident identified in Present Status. Focus 3 addresses aggression. Interventions include use of an anger meter and Enhancing Self Control mall group.	JF	4/1/10	Incident identified in Present Status. Focus 3 addresses failure to control anger. Staff will assist JF in using coping skills in problem situations.	NM	4/10/10	The trigger was noted under Triggers. Focus 3 addressed aggression to self. Interventions include a PBS consult and enrollment in RISE and SAFE.	RK	4/1/10	Trigger noted. Focus 3 addresses suicidal behavior. Interventions include a PBS consult and referral to SAFE.	CH	4/28/10	Trigger not noted. Focus 3 addresses SIB and parasuicidal behavior. Attending SAFE and will be completing a scrapbook.
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		Variable findings resulted from the review of seven individuals who had reached triggers related to falls and selected medical conditions.
Individual	Issue	WRP documentation
JG	Met trigger 7.2 for 3 or more falls in 30 days on 12/28/09	WRP finalized on 12/31/09 listed fall incidents in Present Status section but had no evidence of clinical discussion of trigger. Focus 6.10 open to address learning about fall risk.
JDM	2/16/2010 met trigger 7.1 for fall with major injury	Fall with fracture and ORIF performed; incident not discussed in WRP dated 3/16/10.
IKL	2/4/2010 met trigger 7.1 for fall with major injury	WRP dated 3/1/10 following trigger did not address trigger and reported fall risk as low.
LWS	Choking incident on 2/7/10	Speech Therapy swallowing assessment completed 2/11/10. Diet recommendations and choking risk found in Present Status of 2/25/10 WRP. No open Focus 3 for impulsive behaviors that contributed to choking incident.
GRA	Choking incident on 12/2/09	12/2/09 referral made to Speech Therapy for swallowing assessment. Diet and monitoring recommendations and choking risk found in Present Status of WRP dated 2/17/10. No open Focus 3 for impulsive behaviors that contributed to choking incident.
OVM	New diagnosis of diabetes reported on 11/5/09	Nutrition annual assessment completed 1/21/10 and addressed diabetes diagnosis and contributing factors; no nutrition consult found

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				<p>following diagnosis. Diabetes diagnosis not listed under Axis III. Focus 6.3 open for Type II diabetes and risk for complications of diabetes identified in present status of 3/9/10 WRP.</p>
		<p>AB</p>	<p>New diagnosis of diabetes reported in Medical Conditions database in 1/10</p>	<p>Not reported in treatment plan until the WRP dated 4/7/10. Not listed as Axis III diagnosis; no consult to dietitian upon new diagnosis.</p>
		<p>Current recommendation: Ensure that WRPs consistently address triggers.</p>		
<p>I.2.a. iii</p>	<p>identification of systemic trends and patterns of high risk situations.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide data for the period under review as well as analysis of the figures presented.</p> <p>Findings: Please see I.1.d.i through I.1.d.v, I.2.c and the cells above.</p> <p>Current recommendation: Continue current practice.</p>		
<p>I.2.b</p>	<p>Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:</p>	<p>Compliance: Substantial.</p>		

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I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: All risk management committees are functioning. The facility will soon be providing additional guidance and training to the Program Review Committees to enhance their performance and lessen the burden on the ETRC.</p> <p>Current recommendation: Continue current practice.</p>						
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to expand the monitoring by Standards Compliance of implementation of recommendations.</p> <p>Findings: During the review period, Standards Compliance monitored the implementation of 318 responses from WRPTs, according to facility data. The review of 13 recommendations from March and April ETRC meetings made on behalf of nine individuals found that the succeeding WRPs addressed 12 of the recommendations as completed, in process, or provided a rationale for not implementing the recommendation.</p> <table border="1" data-bbox="953 1192 1900 1408"> <thead> <tr> <th data-bbox="953 1192 1106 1227">Individual</th> <th data-bbox="1106 1192 1507 1227">ETRC recommendation</th> <th data-bbox="1507 1192 1900 1227">Implementation status</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 1227 1106 1408">ALA</td> <td data-bbox="1106 1227 1507 1408">Get neurology consult Consult re: need for transfer Consider neuropsych testing</td> <td data-bbox="1507 1227 1900 1408">WRP 6/3/10: Completed Improved. No need for transfer. Referral for testing completed.</td> </tr> </tbody> </table>	Individual	ETRC recommendation	Implementation status	ALA	Get neurology consult Consult re: need for transfer Consider neuropsych testing	WRP 6/3/10: Completed Improved. No need for transfer. Referral for testing completed.
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I.2.b. iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	<p data-bbox="947 1170 1904 1209">Current findings on previous recommendation:</p> <p data-bbox="947 1243 1904 1315">Recommendation, December 2009: Continue current practice.</p> <p data-bbox="947 1354 1904 1419">Findings: In view of the timely responses of the WRPs to triggers, Risk Management</p>																								

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		<p>recommendations and incidents reviewed, it is reasonable to conclude that the systems for notifying teams and disciplines is functioning well.</p> <p>Current recommendation: Continue current practice.</p>																					
<p>I.2.b. iv</p>	<p>formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Ensure that suicide risk assessments are reviewed and appropriate action taken following suicide attempts.</p> <p>Findings: The WRPTs of the four individuals sampled who had made suicide attempts addressed the attempt with interventions.</p> <table border="1" data-bbox="953 784 1883 1421"> <thead> <tr> <th data-bbox="953 784 1119 862">Individual</th> <th data-bbox="1119 784 1352 862">Approximate date of trigger</th> <th data-bbox="1352 784 1883 862">Addressed/cited in WRP?</th> </tr> </thead> <tbody> <tr> <td colspan="3" data-bbox="953 862 1883 899">Trigger: Aggression to peer resulting in major injury</td> </tr> <tr> <td data-bbox="953 899 1119 1084">LS</td> <td data-bbox="1119 899 1352 1084">4/1/10</td> <td data-bbox="1352 899 1883 1084">WRP 3/30/10 addresses incident of kicking/hitting peer in the head. Focus 3 addresses aggression to others and self. Sent back to prison after this incident.</td> </tr> <tr> <td data-bbox="953 1084 1119 1159">TF</td> <td data-bbox="1119 1084 1352 1159">4/1/10</td> <td data-bbox="1352 1084 1883 1159">WRP 5/5/10 addresses repeated assaults on peers in Focus 3.</td> </tr> <tr> <td data-bbox="953 1159 1119 1308">JF</td> <td data-bbox="1119 1159 1352 1308">4/21/10</td> <td data-bbox="1352 1159 1883 1308">WRP 5/13 notes incident of shoving peer resulting in a rib fracture. Focus 3 addresses failure to resist aggressive impulses.</td> </tr> <tr> <td colspan="3" data-bbox="953 1308 1883 1347">Trigger: Suicide attempt</td> </tr> <tr> <td data-bbox="953 1347 1119 1421">DL</td> <td data-bbox="1119 1347 1352 1421">3/19/10</td> <td data-bbox="1352 1347 1883 1421">WRP: 4/21/10 addresses incident. Psychopharmacology consult completed.</td> </tr> </tbody> </table>	Individual	Approximate date of trigger	Addressed/cited in WRP?	Trigger: Aggression to peer resulting in major injury			LS	4/1/10	WRP 3/30/10 addresses incident of kicking/hitting peer in the head. Focus 3 addresses aggression to others and self. Sent back to prison after this incident.	TF	4/1/10	WRP 5/5/10 addresses repeated assaults on peers in Focus 3.	JF	4/21/10	WRP 5/13 notes incident of shoving peer resulting in a rib fracture. Focus 3 addresses failure to resist aggressive impulses.	Trigger: Suicide attempt			DL	3/19/10	WRP: 4/21/10 addresses incident. Psychopharmacology consult completed.
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		<p>risk profile.</p> <p>Findings: As shown below, the WRPs of 80% of the sampled individuals who had been listed on high risk lists addressed the risk in question.</p> <table border="1"> <thead> <tr> <th>Individual</th> <th>High Risk Category</th> <th>Addressed/Cited in WRP?</th> </tr> </thead> <tbody> <tr> <td>AKA</td> <td>Victimization</td> <td>Noted in Present Status of 6/4/10 WRP</td> </tr> <tr> <td>ALA</td> <td>Victimization</td> <td>Not addressed in 6/23/10 WRP</td> </tr> <tr> <td>JGC</td> <td>Victimization</td> <td>Noted in Present Status of 6/7/10 WRP</td> </tr> <tr> <td>CC</td> <td>Victimization</td> <td>Noted in Present Status of 6/4/10 WRP. Focus 3 cites intrusiveness leading to victimization.</td> </tr> <tr> <td>DJ</td> <td>Victimization</td> <td>Noted in Present Status of 5/24/10. Transfer panel scheduled for assailant.</td> </tr> <tr> <td>DM</td> <td>Victimization</td> <td>Noted in Present Status of 5/12/10 WRP. Aggressor transferred.</td> </tr> <tr> <td>NCA</td> <td>Metabolic syndrome</td> <td>30 day Dietitian consult- 3/24/10 and answered 4/15/10; assessment addressed recommendations for contributing factor of obesity. High risk identified in the Present Status of WRP dated 4/21/10; open Foci 6.2 for overweight and 6.7 for metabolic syndrome. Dietitian objective 6.2.3 and intervention 6.2.3.1 in place to address obesity.</td> </tr> <tr> <td>JJM</td> <td>Metabolic syndrome</td> <td>High risk identified in the Present</td> </tr> </tbody> </table>	Individual	High Risk Category	Addressed/Cited in WRP?	AKA	Victimization	Noted in Present Status of 6/4/10 WRP	ALA	Victimization	Not addressed in 6/23/10 WRP	JGC	Victimization	Noted in Present Status of 6/7/10 WRP	CC	Victimization	Noted in Present Status of 6/4/10 WRP. Focus 3 cites intrusiveness leading to victimization.	DJ	Victimization	Noted in Present Status of 5/24/10. Transfer panel scheduled for assailant.	DM	Victimization	Noted in Present Status of 5/12/10 WRP. Aggressor transferred.	NCA	Metabolic syndrome	30 day Dietitian consult- 3/24/10 and answered 4/15/10; assessment addressed recommendations for contributing factor of obesity. High risk identified in the Present Status of WRP dated 4/21/10; open Foci 6.2 for overweight and 6.7 for metabolic syndrome. Dietitian objective 6.2.3 and intervention 6.2.3.1 in place to address obesity.	JJM	Metabolic syndrome	High risk identified in the Present
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				Status of WRP dated 3/11/10; open Foci 6.1 for diabetes type 2, 6.2 for hypertension and 6.3 for obesity. Dietitian objective 6.3.3 and intervention 6.3.3.1 in place to address obesity.
		JB	Metabolic syndrome	High risk identified in the Present Status WRP dated 4/12/10, open Foci 6.3 for dyslipidemia, 6.12 for hypertension and 6.18 for obesity. Dietitian objective 6.18.4 and intervention 6.18.4.1 in place to address obesity.
		AC	Metabolic syndrome	High risk identified in the Present Status of WRP dated 5/11/10. Dietitian assessment completed that focused on obesity; recommendations not included in the WRP. Open Foci 6.6 for overweight, 6.7 for hypertension, and 6.12 for metabolic syndrome.
		EG	Metabolic syndrome	Individual identified as at high risk on 5/20/10 but no RD referral ordered.
		MLS	Impaired skin integrity	High risk not identified in WRP's dated 4/15/10 or 5/13/10.
		SN	Impaired skin integrity	High risk identified in the Present Status of WRP dated 6/7/10; Focus 6.5 open with objective and intervention to address impaired skin integrity risk related to diabetic complications.
		JWL	Aspiration and	High risk identified in the Present

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			choking	Status of WRP dated 5/20/10; Focus 6.2 focus open with objective and intervention in place to address choking risk during mealtimes.
		RKB	Aspiration	High risk identified in the Present Status of the WRP dated 4/14/10; no open Focus 6.
		JH	Choking	High risk identified in the Present Status of the most recent WRP dated 5/10/10; Focus 6.19 objective and intervention in place to address choking risk during mealtimes.
		DG	Falls	High risk identified in the Present Status of the most recent WRP dated 4/28/10 due to history of ORIF surgery, pain. No Focus 6 objective and intervention in place to address fall risk. PT evaluation done on 1/12/10 but physical therapy not indicated- Orthopedic referral recommended in PT assessment and sent on 4/5/10.
		JRB	Falls	High risk identified in the Present Status of the most recent WRP dated 5/26/10. Physical therapy assessment completed on 2/20/09.
		<p>Current recommendation: Ensure that WRPs consistently address individuals' high risk status.</p>		

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<p>I.2.c</p>	<p>Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Review of the Quality Council minutes revealed the facility's attention to the issue of violence. Examples include:</p> <ul style="list-style-type: none"> • The Medical Director explained the steps that have been taken to reduce violence on Unit 32 in the November minutes. These steps include stabilizing nursing staff and the assignment of two new psychiatrists and a new Unit Supervisor. • The Executive Director noted in the January minutes the increase in peer-to-peer aggression provoked by the intent to "get even." He further noted that Dr. Christison is developing a committee to look at this issue. • The February minutes note the increase in aggressive acts toward staff. Dr. Christison's committee has been formalized as the Aggression Reduction Task Force Committee. • During the March meeting, participants reviewed graphed data on violence for the period May 2006-January 2010 that showed peer-to-peer aggression increasing, peer-to-staff aggression showing a downward trend and staff injuries showing an upward trend with more staff going to community resources for evaluation and treatment. • The April minutes note the increase in aggression between 8:00-8:30 AM and asked the individuals present for suggestions about why this might be. The individuals cited irritability upon awakening, change of shift "busy-ness" and medication distribution. These latter two leave fewer staff to care for the needs of specific individuals. <p>The facility reports that two projects in addition to the Violence Reduction Initiative are underway: Water Intoxication Treatment Protocol</p>
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		<p>development and implementation and Program Wide Trainers—clinicians assigned to Standards Compliance who provide written and verbal instruction on what needs to be changed in a WRP for it to meet EP standards.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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3. Environmental Conditions		
I.3	<p>Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:</p>	<p>Methodology:</p> <p><u>Interviewed:</u></p> <ol style="list-style-type: none"> 1. B. Ray, Health and Safety Officer 2. B. Sherer, Hospital Administrator 3. E. Halsell, Chief of Plant Operations 4. E. Juarez, Supervising Housekeeper 5. M. Mosk, PhD, Psychologist on Unit EB-10 <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Unit 20 cord and adapter accountability logs 2. WRPs of 10 individuals with incontinence 3. Health and Safety officer Status Report for the review period 4. Environmental Random Spot Checks 5. Environment of Care Survey data 6. Environment of Care Grid <p><u>Toured:</u></p> <p>Six units: 20, 32, 77, 71, EB-10, EB-01</p> <p><u>Inspected:</u></p> <p>Prototype of the new locker</p>
I.3.a	<p>Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Determine if evening staff on EB-10 have sufficient signing skills to communicate effectively with individuals.</p> <p>Findings: Individuals and staff on EB-10 stated that evening staff still lack sufficient signing skills to communicate effectively. The facility reported that six</p>

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		<p>staff are assigned to the PM shift on EB-10 and, while none of these staff are bilingual, all but one can hold a simple conversation using ASL. These staff are reported to be attending at least one ASL class weekly.</p> <p>Other findings: The facility's data indicates that a minimum of 10 individual-occupied areas were inspected each month during the review period, and in each instance in which a deficiency was noted, the program responded with a corrective action plan.</p> <table border="1" data-bbox="955 565 1906 941"> <thead> <tr> <th>Date of survey</th> <th>Number of individual-occupied areas inspected</th> <th>Number of inspections with deficiencies reported to the program</th> <th>Number of Programs that responded with a POC</th> </tr> </thead> <tbody> <tr> <td>Nov 2009</td> <td>10</td> <td>2</td> <td>2</td> </tr> <tr> <td>Dec 2009</td> <td>12</td> <td>3</td> <td>3</td> </tr> <tr> <td>Jan 2010</td> <td>13</td> <td>2</td> <td>2</td> </tr> <tr> <td>Feb 2010</td> <td>12</td> <td>2</td> <td>2</td> </tr> <tr> <td>March 2010</td> <td>15</td> <td>1</td> <td>1</td> </tr> <tr> <td>April 2010</td> <td>12</td> <td>2</td> <td>2</td> </tr> </tbody> </table> <p>In addition to the planned Environment of Care monthly inspections by the Health and Safety Environmental Survey Team, this team performed seven random spot checks on seven units during the review period. No problems were identified on four units. One inspection noted water damage and missing privacy curtains on Unit 75. Dust in the windows was noted on Units N-24 and N-25. The facility reports that all units were notified of the findings.</p> <p>The Health and Safety Officer evaluates the monthly inspection reports submitted by Unit Supervisors to ensure that they are complete and thorough. The facility data provided states that for each unit the monthly US inspections addressed specific suicide risks and cleanliness issues and</p>	Date of survey	Number of individual-occupied areas inspected	Number of inspections with deficiencies reported to the program	Number of Programs that responded with a POC	Nov 2009	10	2	2	Dec 2009	12	3	3	Jan 2010	13	2	2	Feb 2010	12	2	2	March 2010	15	1	1	April 2010	12	2	2
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		<p>are consisted with the H&S Inspection Survey Team notes.</p> <p>Attention to devices that could be used for hanging has been ongoing for the last several years as cited from the Environment of Care Grid provided by the facility.</p> <table border="1" data-bbox="955 414 1885 1347"> <thead> <tr> <th data-bbox="955 414 1323 451">Issue</th> <th data-bbox="1323 414 1885 451">Current Status</th> </tr> </thead> <tbody> <tr> <td data-bbox="955 451 1323 565">Replacement of doorknobs that could be used for hanging</td> <td data-bbox="1323 451 1885 565">Estimated cost of project is \$1.1M. Work suspended until 2011.</td> </tr> <tr> <td data-bbox="955 565 1323 711">Replacement of door hinges that could be used for hanging</td> <td data-bbox="1323 565 1885 711">Not funded for budget year 2008/2009. DMH is requesting a study of feasibility of new buildings versus the cost of renovating old buildings.</td> </tr> <tr> <td data-bbox="955 711 1323 857">Removal of exterior window grilles that could be used for hanging</td> <td data-bbox="1323 711 1885 857">The facility has received a waiver from the State Fire Marshall for the limited use of Lexan. This will be placed over any remaining exterior bars.</td> </tr> <tr> <td data-bbox="955 857 1323 1003">Replacement of reading lights in bedrooms that present a hanging hazard.</td> <td data-bbox="1323 857 1885 1003">Renovation of the EB Building has been delayed. DMH is requesting a study of feasibility of new buildings versus the cost of renovating old buildings.</td> </tr> <tr> <td data-bbox="955 1003 1323 1149">Replacement of wardrobes</td> <td data-bbox="1323 1003 1885 1149">Production of new wardrobes is scheduled to begin in June 2010. Delivery is expected to begin in July 2010 at a rate of 200 units/month.</td> </tr> <tr> <td data-bbox="955 1149 1323 1347">Replacement of bathroom fixtures</td> <td data-bbox="1323 1149 1885 1347">Shower valves have been replaced with push-button models in the 30 Building, the N Building, and the 70 Building. The U and EB Buildings will be completed when resources permit.</td> </tr> </tbody> </table> <p>Strict accountability for adapters and electrical cords was a</p>	Issue	Current Status	Replacement of doorknobs that could be used for hanging	Estimated cost of project is \$1.1M. Work suspended until 2011.	Replacement of door hinges that could be used for hanging	Not funded for budget year 2008/2009. DMH is requesting a study of feasibility of new buildings versus the cost of renovating old buildings.	Removal of exterior window grilles that could be used for hanging	The facility has received a waiver from the State Fire Marshall for the limited use of Lexan. This will be placed over any remaining exterior bars.	Replacement of reading lights in bedrooms that present a hanging hazard.	Renovation of the EB Building has been delayed. DMH is requesting a study of feasibility of new buildings versus the cost of renovating old buildings.	Replacement of wardrobes	Production of new wardrobes is scheduled to begin in June 2010. Delivery is expected to begin in July 2010 at a rate of 200 units/month.	Replacement of bathroom fixtures	Shower valves have been replaced with push-button models in the 30 Building, the N Building, and the 70 Building. The U and EB Buildings will be completed when resources permit.
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		<p>recommendation following the suicide of MB on 1/4/10 on Unit 20. Review of the implementation of the recommendation yielded variable findings. First, detachable cords and adapters were labeled with the owner's name and stored in the nursing station. A log listed the names of individuals and the number of cords and adapters each owns. As an individual checked out a cord or adapter this was noted on the log. <u>A count of the adapters and cords matched the log, indicating that all were accounted for.</u> There was a problem, however, because this equipment was not logged in when it was returned. Additionally, although the staff asserted that when the equipment is returned at the end of the day (at about 9:00PM) a count is completed to ensure that all have been returned, there was no documentation of the count. In response to this finding, Unit 20 immediately adopted a system for signing the equipment in and out and an accountability sheet for the end of the day count initialed by the staff member completing the count. By the close of the CM visit, the facility leadership said the Unit 20 accountability plan would be implemented facility-wide.</p> <p>The facility has been working on a prototype of a wardrobe for the last six months. It has finalized the design. Prison Industries will produce the wardrobes, which have a slanted top and sliding rather than hinged doors. The facility expects the first shipment of 200 to be delivered in July, with 200 expected each month at a cost of nearly \$1000 per wardrobe.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Implement, as planned, Unit 20 accountability procedures for cords and adapters facility-wide.</p>
I.3.b	All areas of the hospital that are occupied by individuals being served have adequate	Current findings on previous recommendation:

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	<p>temperature control and deviations shall be promptly corrected;</p>	<p>Recommendation, December 2009: Continue current practice.</p> <p>Findings: Facility policy categorizes work orders related to temperature as Urgent Work Orders. The facility reported that all Urgent Work Orders were responded to within the same or by the next day. During the review period, the mean number of Urgent Work Orders per month was 179. Urgent Work Orders related to hot temperatures averaged 46 per month during the reporting period. Those related to cold temperatures averaged 37 per month.</p> <p>Other findings: During the tour, the residential units were of a comfortable temperature. No individuals complained about the temperature.</p> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>				
<p>I.3.c</p>	<p>Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue to ensure that individuals with the problem of incontinence are provided care and assistance appropriate to their needs.</p> <p>Findings: The facility reported the following data for the review period.</p> <table border="1" data-bbox="953 1338 1892 1409"> <thead> <tr> <th data-bbox="953 1338 1646 1377">Criterion</th> <th data-bbox="1646 1338 1892 1377">Compliance rate</th> </tr> </thead> <tbody> <tr> <td data-bbox="953 1377 1646 1409">Incontinence status is addressed in Present Status</td> <td data-bbox="1646 1377 1892 1409">76%</td> </tr> </tbody> </table>	Criterion	Compliance rate	Incontinence status is addressed in Present Status	76%
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		<table border="1" data-bbox="955 190 1892 345"> <tr> <td>Incontinence identified in Focus 6</td> <td>95%</td> </tr> <tr> <td>Objectives promote dignity and self-reliance</td> <td>97%</td> </tr> <tr> <td>Individual is clean, dry and odor-free</td> <td>100%</td> </tr> <tr> <td>Nursing staff explain how they assist the individual</td> <td>100%</td> </tr> </table> <p>Other findings: The review of the WRPs of ten individuals identified as having the problem of incontinence found that the problem was addressed in nine—a finding consistent with the facility's internal audit findings reported above.</p> <table border="1" data-bbox="955 565 1885 987"> <thead> <tr> <th>Individual</th> <th>Focus 6</th> <th></th> </tr> </thead> <tbody> <tr> <td>GG</td> <td>6.5</td> <td>Addresses urinary incontinence</td> </tr> <tr> <td>HE</td> <td>6.14</td> <td>Addresses incontinence when laughing/coughing</td> </tr> <tr> <td>JC</td> <td>6.23</td> <td>Addresses occasional enuresis</td> </tr> <tr> <td>JJ</td> <td>6.7</td> <td>Addresses nocturnal incontinence</td> </tr> <tr> <td>LF</td> <td>6.24</td> <td>Addresses urinary incontinence</td> </tr> <tr> <td>PB</td> <td>6.12</td> <td>Addresses urinary incontinence at night</td> </tr> <tr> <td>RJ</td> <td>6.12</td> <td>Addresses enuresis</td> </tr> <tr> <td>SD</td> <td>6.1</td> <td>Addresses incontinence at night</td> </tr> <tr> <td>SH</td> <td>6.26</td> <td>Addresses need for protective garment at night</td> </tr> <tr> <td>SK</td> <td></td> <td>No mention of incontinence</td> </tr> </tbody> </table> <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>	Incontinence identified in Focus 6	95%	Objectives promote dignity and self-reliance	97%	Individual is clean, dry and odor-free	100%	Nursing staff explain how they assist the individual	100%	Individual	Focus 6		GG	6.5	Addresses urinary incontinence	HE	6.14	Addresses incontinence when laughing/coughing	JC	6.23	Addresses occasional enuresis	JJ	6.7	Addresses nocturnal incontinence	LF	6.24	Addresses urinary incontinence	PB	6.12	Addresses urinary incontinence at night	RJ	6.12	Addresses enuresis	SD	6.1	Addresses incontinence at night	SH	6.26	Addresses need for protective garment at night	SK		No mention of incontinence
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I.3.d	Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the hospital. Each State hospital shall	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Provide the findings from monitoring of WRPTs' responses to sexual</p>																																									

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	<p>establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and</p>	<p>incidents.</p> <p>Findings: The facility indicated that it had monitored 14 sexual incidents, but did not provide the findings.</p> <p>Other findings: In one of the three sexual incidents reviewed, the individual withdrew the allegation. TM withdrew the allegation that she was sexually abused by a staff member on 9/11/09—an allegation not reported until nine weeks after the alleged event. The incident was noted in the victim's WRP. The allegation of sexual assault made by CH was not substantiated after two individuals identified as witnesses denied the incident occurred. The incident was referenced in the victim's WRP. The 11/16/09 incident in which a male individual alleged he was touched inappropriately by a female individual was not referenced in the victim's WRP.</p> <p>Compliance: Partial, based on limited information.</p> <p>Current recommendation: Provide the findings from monitoring of WRPTs' responses to sexual incidents.</p>
<p>I.3.e</p>	<p>Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.</p>	<p>Current findings on previous recommendation:</p> <p>Recommendation, December 2009: Continue current practice ensuring the availability of and monitoring of training for Mall facilitators.</p> <p>Findings: The facility's data indicates substantial compliance with the expectation that non-clinical staff members will complete a specific training curriculum.</p>

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		Course	May 2009 - October 2009	November 2009 - April 2010
		PMAB	97%	99%
		CPR	92%	97%
		First Aid	94%	97%
		Recovery (Chapter 1)	86%	89%
		By Choice	90%	96%
		Patients Rights	92%	97%
		Neglect and Abuse	97%	99%
		Mean Compliance Rate	93%	96%
		<p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice, including monitoring.</p>		

J. First Amendment and Due Process		
J		<p>Summary of Progress:</p> <ol style="list-style-type: none"> 1. The documents provided and the interview with Ms. Clark confirmed that the facility continues not only to be attentive to the concerns of individuals but to empower individuals. 2. Two individuals have seats on the Quality Council and have input into the development and revision of ADs. 3. The systematic identification of concerns by the Cooperative Council, the standardized procedures for bringing these to the attention of facility leadership, and the willingness of the individuals to acknowledge positive changes identify this Council as exemplary.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	<p>Methodology:</p> <p><u>Interviewed:</u> Cynthia Clark, Administration Liaison to Individuals</p> <p><u>Reviewed:</u></p> <ol style="list-style-type: none"> 1. Central Council meeting minutes for January-May 2010 2. Individuals' Survey 3. Graphed survey results 4. Central Council Senate Roadmap for 2010
J		<p>Current findings on previous recommendations:</p> <p>Recommendation 1, December 2009: Continue to work toward a telephone system that reduces impediments to maintaining communication with family, friends and legal representatives.</p> <p>Findings: All of the Central Council minutes reviewed address the question telephone access and services. The Roadmap for 2010 states that PSH obtained a new</p>

statewide telephone service contract with Pacific Telephone Service, which is more responsive to concerns regarding services and repairs and has reduced the collect call rates; fewer individuals are having problems with blocked numbers.

Recommendation 2, December 2009:

Investigate the conditions that individuals describe enduring during outside medical appointments. Take measures to correct any conditions that unnecessarily compromise an individual's dignity. The first provision of the Protection from Harm section of the EP requires a humane environment.

Findings:

The May 21 Central Council minutes note that the Chief of Medical Services Dr. Mach and RN Supervisor J. Diaz attended the May 14 Hospital-Wide Senate meeting to discuss inside and community medical appointments. Dr. Mach spoke about his efforts to bring specialists to Patton. He has succeeded in arranging for consultation and treatment services on site for a surgeon specializing in infectious diseases, a physician specializing in rehabilitation, a gastroenterologist and a neurologist. He is continuing to try to recruit a dermatologist and a pulmonologist. Both of the speakers addressed the wisdom of addressing problems while they are small and continuity of care. Both the speakers and the individuals were pleased with the encounter, according to the minutes.

Other findings:

With the exception of the question asking if individuals believe staff believe they can get better, the answers to the other sampled questions remained essentially unchanged from the responses six months earlier.

Item	Percentage of positive responses	
	August 2009	February 2010
Feel safe?	71%	67%
Treated with respect?	72%	71%

Environment clean?	72%	71%
Encouraged to be of service to others?	55%	55%
Staff make sure rules are followed?	76%	74%
Unit's rules are fair?	69%	70%
Staff believe I can get better?	82%	75%
I have input into hospital rules and policies.	55%	53%

The facility provided survey data on a program-by-program basis as well as on a facility wide basis.

The Roadmap for 2010 lists the top eight concerns of the Council Senate as shown below:

Issue	2010 Rank
Unchecked violence continues to affect the quality of life at the hospital	1
Quality of Mall Groups	2
Telephone system with fewer restrictions	3
Designate one time slot per week in the afternoon for ward government meetings hospital-wide	4
Staff are so preoccupied with the EP that they have no time for us	5
We ought to be able to spend our own money as and when we choose	6
The growing frequency and poor quality of "alternative mall" treatment	7
Medical care at outside facilities	8

		<p>The second portion of the document is titled "Heartening Progress." The acknowledged improvements include:</p> <ul style="list-style-type: none"> • Very positive changes in the Visiting Center resulting from the facility taking over most of the processes from CDCR. • Individuals are getting their packages much more expeditiously. • By Choice points are being posted daily. There is a greater variety of items added to the menu. By Choice is vastly improved over last year. • The evening and weekend leisure and recreation activities of the Supplemental Activity Program are valuable and fun. • The cleanliness of the units is generally improving. This is assisted by the absence of cigarette butts. During each meeting of the Senate, a clipboard is passed on which to report environmental concerns. This is provided directly to the Health and Safety Officer. • Treatment conferences have increased in quantity and quality. • Individuals' access to the policy-making process at the facility continues to improve and grow. Two individuals represent the interests of all individuals at the Quality Council, giving individuals input in the review of facility policies. Additionally, individuals are working to create an AD about patient government at the facility. • The Distance Learning Program via Coastline College is a "dream come true." • More individuals have Industrial Therapy assignments and are working for pay. <p>Compliance: Substantial.</p> <p>Current recommendation: Continue current practice.</p>
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